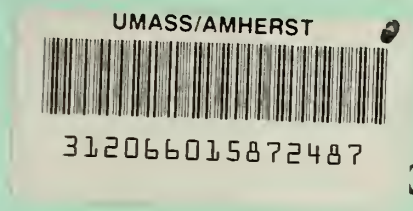

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Mental Health

Adult & Child-Adolescent Progress Reports on the Comprehensive Mental Health Service Plan

Fiscal Year 1992

December 31, 1992

COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF MENTAL HEALTH

Adult & Child-Adolescent Progress Reports on the COMPREHENSIVE MENTAL HEALTH SERVICE PLAN

Fiscal Year 1992

Submitted as part of the 1993 Block Grant Application (P.L. 102-321)

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INTRODUCTION

The September, 1991 Progress Report outlined the Massachusetts Department of Mental Health's (DMH) commitment to the planning and development of a consumer driven, comprehensive system of care for seriously mentally ill adults and seriously mentally ill and severely emotionally disturbed children and adolescents. DMH's goals for accomplishing this task were embodied in the concepts of public **Managed Care, Accountability** and **Partnership**. DMH has made remarkable progress toward achieving a community based system of care since the inception and implementation of the P.L.99-660 planning process.

DMH is presently engaged in a comprehensive reorganization of its service system. This reorganization is aimed at shifting resources from state hospital inpatient care to an expanded community based service system for adults, children and adolescents that is responsive to the preferences and needs of its recipients and removes barriers to access often experienced by communities of color, multicultural and linguistic minority groups. It has involved hundreds of consumers, family members, providers, advocates and professionals as well as DMH staff. Public Managed Care, the goal of DMH's initiative to restructure its system, is predicated on the building of a community based system of care and an anticipated reduction in utilization of inpatient care. DMH has utilized facility closure and consolidation, privatization of acute inpatient care and collaboration with the Medicaid division of the Department of Public Welfare's mental health and substance abuse managed care initiative as the mechanisms to achieve its goal.

The Department closed two of its seven (adult) state hospitals in FY'92 A third will be closed in May, 1993. A total of 543 new residential beds were added during the year to expedite the closure and consolidation process. In addition, the Governor's Special Commission recommended closing the Gaebler Children's Center, the only state

hospital for children 14 and under, in favor of community-based alternatives. This was accomplished on September 30, 1992. These closures enable DMH to redirect state hospital funding to the development of acute inpatient care (for adults in general and private psychiatric hospitals), intensive residential treatment (for adolescents), community residential, case management, day and other home-based and community support services, and to close facilities that are often removed from the locus of community services and supports. In particular, the transfer of acute inpatient care from state to community hospitals is intended to reduce stigmatization of the seriously mentally ill by integrating mental health care into the general health care system. Furthermore, the Department intends to take the necessary steps to ensure that all remaining state hospitals, community mental health centers and other eligible community programs receive and/or maintain certification and accreditation. The pace and magnitude of this change are unprecedented for the Commonwealth.

The development of public managed care will only be as effective as the organizational context within which it is incorporated. Therefore, the community based service system is not only being expanded, but it is also being reorganized into a Comprehensive Community Support System (CCSS) design, in each "natural service area" of the state. This initiative, described in the last P.L. 99-660 Progress Report, resulted in the Commissioner's approval of identified "natural service areas" in eight of the nine DMH Areas. The CCSS design will enable the various system components to be better coordinated and consumer driven, will facilitate linkages among the various system components and is expected to be more flexible and responsive to consumer and family need, populations with special service needs and multicultural and linguistic minority groups. Through the CCSS, the Department will be able to manage the entire array of services consumers need and receive. In order to ensure accountability, accessibility - including access for cultural and linguistic minorities - quality and cost effectiveness, the Department is developing a comprehensive quality

management program. When the quality management program is fully implemented, ongoing assessment and improvement will occur throughout all levels of the organization from the central office of DMH to the provider level.

Simultaneously, the Department of Public Welfare, the state's Medicaid agency, is engaged in the development of a managed care system for its mental health and substance abuse services. This initiative is being implemented by a private vendor, Mental Health Management of America, Inc. (MHMA). DMH is working cooperatively with MHMA to plan jointly for the provision of Medicaid funded services to the Department's adult, child and adolescent priority clients. There are joint forums established for the purpose of coordinating efforts around the purchase of acute inpatient care as well as community based emergency, diversion, case management, and other support services. Systematically, the two entities are jointly developing standards of care and opportunities for blended funding. The goals are to create a managed care system that will ensure that inpatient care is minimized as much as possible in favor of community service utilization and that a seamless system is created that will simplify service access for the consumer.

MHMA is working on redirecting its Medicaid funds towards further expansion of community diversion and other alternative services. DMH, which is engaged in the same process, is coordinating its CCSS service system development with MHMA. For example, both entities are collaborating around contracting for emergency services and the development of community-based hospital diversion services DMH presently funds, but does not have a comprehensive array of diversion services available MHMA will be expanding the array of these services by building upon the already established DMH funded base network. This will be accomplished through a cooperative process of issuing Requests for Proposals and reviewing bids

As it restructures its service system through the CCSS planning process, DMH also intends to relook at the role and functions of its nine Area offices. As the Areas

operationalize their CCSS's they will also investigate ways to receive Medicaid and other public and private dollars in addition to DMH funds. Blending of these various

funding streams to purchase a comprehensive system of care and protecting the service system from political shifts are the desired outcomes. The Area offices will be responsible for managing the service delivery system within each CCSS, will be accountable for its performance, and will continue to provide the conceptual framework for implementing a system of public managed care. It is conceivable that as the system takes hold, one or more Areas may choose to become local mental health authorities if that type of organizational and fiscal entity is deemed more advantageous in carrying out the above principles.

DMH anticipates the end product of all of these initiatives to be the development of a system of public managed care for its priority clients that is coordinated and well managed. This new system will be embedded within the CCSS organizational design and coordinated and integrated through each Area office. Services will be delivered according to individual consumer need.

DMH intends to couple the structural reorganization of the system with an improved data management system that streamlines and integrates data collection and provides the Department with the information it needs to support ongoing and active planning and program development.

Finally, the Department will continue to support consumer, family member and community involvement within DMH to ensure that planning and program development are accessible and responsive to, and consistent with, consumer preference and need and the recognized needs of multicultural and linguistic minority groups. In this regard, the Office of Consumer and Ex-Patient Relations, the Consumer Advisory Council and the Multi-Cultural Advisory Committee, established within DMH in FY'92, will continue to play important roles.

This has been a year of significant changes and accomplishments for the Massachusetts Department of Mental Health. The Department has implemented most of the goals and objectives in its approved plan, and has initiated an intensive planning process to develop and implement the remainder of a comprehensive community-based system able to serve adults with serious mental illnesses and children and adolescents with serious mental illnesses or severe emotional disturbances.

The Progress Reports that follow provide the details of **DMH's accomplishments** since the beginning of P.L. 99-660 planning (1987 base year), **revised goals and objectives** (since September, 1991 approved State plan), and **new goals and objectives** DMH expects to begin and/or complete during 1993.

The Progress Reports for both the Adult and Child/Adolescent systems follow the format and guidelines provided by the National Institute of Mental Health in June, 1992 and describe the status of implementation of the 1991 approved State plan. In both Progress Reports, the Department selected indicators for each Requirement that demonstrate movement towards implementation.

PART A: IMPLEMENTATION REPORT TOPICS

ADULT PROGRESS REPORT

REQUIREMENT #I: The State plan shall provide for the establishment and implementation of an organized community-based system of care for individuals with serious mental illnesses.

An organized, comprehensive community-based system of care must be guided by a consistent, continuous and cohesive participatory planning process and anchored by standards and regulations that ensure quality of care, appropriate oversight and a mechanism for continuous assessment and improvement. Furthermore, the recipients of mental health services, adults with serious mental illnesses, including members of cultural and linguistic minority groups who have historically experienced difficulty gaining access to mental health services, must be included actively in the planning and standard-setting processes. Therefore, the Department has chosen **Regulations and Standards, Planning, and Consumer** and **Community Involvement** as the indicators to demonstrate implementation of this Requirement.

A. Regulations and Standards

Base Year:

- There was no statewide Quality Assurance (QA) mechanism.
- Inpatient care was provided primarily in non-certified and non- accredited facilities
- State proposed to reform purchase of service system to include measures of programmatic performance.
- The Citizen Monitoring Project (CMP) was developed jointly by the Alliance for the Mentally Ill of Massachusetts (AMI) and DMH in May, 1987 to provide citizen monitors at the state hospitals. A standard monitoring form and reporting protocol were developed to provide recommendations to DMH on inpatient conditions.
- There was no uniform DMH client eligibility policy.

Most Recently Approved Plan (September, 1991):

- Develop standards defining the integration of a Comprehensive Community Support System (CCSS) by April, 1992.

- Establish guidelines for quality assurance activities within the acute psychiatric units developing in private and community hospitals as DMH replacement units or DMH affiliate units (FY'92).

- Develop and implement incorporation of performance indicators into all purchase of service contracts by 6/30/93.

- Maintain existing certification and certify or re-certify six inpatient facilities between 06/30/90 and 06/30/92.

- Ensure that Requests for Proposals (RFP) for acute care units in private and community hospitals and vendor-operated programs include provisions for a citizen monitoring program (July, 1992).

Revised or Additional 1992 Goals:

- Develop and implement a quality management (QM) infrastructure to support ongoing and systematic assessment and improvement activities throughout the system including the DMH Central Office and Area Offices, and all community providers (Provider self-monitoring) by October 1, 1993.

- Expand the development of clinical standards of care to include all program elements identified in the CCSS (inpatient, emergency, outpatient, residential, case management, day/evening) by October 1, 1993.

- Incorporate DMH guidelines for QA activities and a requirement for citizen monitoring into the standard contract for acute psychiatric replacement units developed in private and general hospitals (December, 1992).

- Incorporate DMH guidelines for QA activities into the standard contract for non-acute psychiatric replacement units developed in private and community hospitals (December, 1992)

- Maintain/expand certification or accreditation of state hospitals and inpatient units of state operated CMHC's (ongoing).

- Revise target date to develop and implement incorporation of performance indicators into all purchase of service contracts as they come up on bid cycle (6/30/96)

- Revise target date for implementation of citizen monitoring in vendor-operated residential programs to coincide with the date residential contracts come up for bid on the 5-year bid cycle, ensure that RFP's for non-acute care units in private and community hospitals include provisions for citizen monitoring

- Revise state DMH regulations regarding organization of Areas and citizen advisory groups to support CCSS implementation (October 1, 1993).

- Complete implementation guidelines for Policy # 89-3, regarding client eligibility for DMH services, to ensure uniform interpretation of the policy in all DMH Areas (October 1 1993)

Current Implementation/Accomplishments:

- Quality Management standards for the CCSS were developed and published in the CCSS guidance manual, Massachusetts Department of Mental Health, Developing Comprehensive Community Support Systems: A Guidance Manual for Area Participatory Planning, March, 1992

- Performance outcome measures were developed (by program code) and incorporated into RFP's and FY'93 contracts for case management, community support, community and school therapy comprehensive medical services, comprehensive psychiatric services, consumer/family care, dentistry, evening and weekend coverage and outpatient services/programs Contract specific performance outcomes were developed for comprehensive staff training and pharmacy

- Performance outcome measures for staffed apartment, community support clubhouse, supported employment, high intensity residential , sheltered workshop, prevocational skills building and psychiatric day treatment are incorporated into existing contracts Measures for contracts coming up for FY'94 will be completed in January, 1993 and outcome measures for subsequent cycles will be developed on an ongoing basis and incorporated into contracts as each program code comes up for open bidding on the 5-year bid cycle. At the direction of the Executive Office of Administration and Finance, the original schedule was interrupted, but was reinstated for FY'93 contracts. This cycle concludes in FY'96 for FY'97 contracts

- The standard contract developed by DMH for inpatient replacement units requires the private or general hospital to conduct specific DMH approved QA activities, identifies reporting requirements, and requires development of a citizen monitoring program.

- The Licensing and QM systems were streamlined (i.e. the licensing instrument was revised), such that neither entity duplicates areas of responsibility allocated to the other entity.

- Residential QM standards/indicators were developed, and a draft instrument (Certification Review) was developed to measure program compliance with the identified standards The final draft of Community Support Clubhouse standards was circulated for review and comment in December 1992.

- A draft (residential) Certification Review instrument was piloted statewide during FY'92 Training on this process was provided.

- In September, 1992, the Office of Quality Management began a training series on Provider self-monitoring.

- DMH developed a comprehensive record review system.

- Three acute replacement units in private/general hospitals and a Department of Public Health hospital that serves up to 180 intermediate and continuing care DMH priority clients that became operational in FY'92 include plans for or are operating a citizen monitoring program.

Comparison with Base Year:
In FY'87, QA was equated to "program evaluation," a retrospective look at the quality of a program, rather than a proactive system, designed to monitor and evaluate the effectiveness of inpatient and community programs. While some Areas utilized the Central Office QA instrument to evaluate provider agencies, other Areas utilized their own QA measures. Additionally, the QA instrument utilized in FY'87 was not a comprehensive survey, designed to measure the quality and effectiveness of a program. Though it consisted of a series of standards, it failed to offer criteria by which to measure compliance with the standards. Thus, survey results tended to be subjective in nature. In addition, DMH's licensing program duplicated many areas that fell under the jurisdiction of QA.

As documented above, significant progress has been made in QA. Monitoring systems are in place to monitor and evaluate community programs and QA programs were established for inpatient services. The FY'93 goal is to develop a structure that will support comprehensive and integrated assessment and improvement activities across all DMH operated or funded programs.

Several other pieces of the system are in place. These include the following: (1) comprehensive review of consumer records; (2) health and safety review; (3) a comprehensive review of the quality and effectiveness of provider services.

The Provider self-monitoring series will instruct QM staff how to help providers organize and implement a self-monitoring program, ensuring that providers develop and implement proactive systems to monitor the quality and effectiveness of the services they provide.

The DMH comprehensive record review system provides that consumer records are reviewed yearly for the following residential prototypes: specialized residential, high intensity residential, moderate intensity residential; low intensity residential; and flexible support residences.

As part of the outcome-based monitoring system, outcome data are collected twice yearly. DMH also collects program-specific satisfaction information from its consumers twice yearly, to ensure that consumers are satisfied with the services they receive. This information will be used to effect necessary changes. DMH is mindful of the fact that some consumers are unable or unwilling to respond to surveys, and must take steps to ensure the views of those consumers are considered as well

DMH recently placed the responsibility for responding to CMP issues at the Operations/Area Director level. The program has expanded to include human rights, client funds, dietary issues, canteen funds and most recently, seclusion and restraint procedures and practices. DMH is working with the Massachusetts Hospital Association to implement citizen monitoring programs in private acute care facilities which contract with DMH to provide services.

Six hundred and thirty-one (631) state-operated inpatient beds are now HCFA certified, 389 are JCAHO accredited, and 169 are both certified and accredited.

To date, DMH has articulated Residential standards and indicators, as well as generic QM standards and indicators. Standards for Community Support Clubhouses are being reviewed. DMH recently developed its consumer satisfaction survey for inpatient acute and continuing hospitalizations.

CMP visits are conducted monthly at all state hospitals and inpatient units of state operated community mental health centers. A CMP steering committee meets quarterly to address statewide issues identified through the monitoring process. This committee includes senior level DMH staff and representatives from Mass/AMI. The DPH hospital which admits DMH priority patients has implemented a CMP as will all other replacement units as they come on line.

After 1986 legislation which separated DMH into two agencies - DMH and the Department of Mental Retardation - and narrowed DMH's mission, DMH convened a task force of consumers, family members, mental health professionals, advocates, providers, other state agencies and DMH staff to draft a policy on eligibility criteria for DMH clientsto properly define DMH priority clients and establish appropriate criteria for targeting services to them. The separation took effect July 1, 1988 and the eligibility policy was adopted in April, 1989. The Department is currently engaged in a project to draft implementation guidelines for this policy to ensure its uniform application across Areas.

Supporting Narrative:

Although care of clients in community programs is evaluated and monitored in other ways, inclusion of citizen monitoring program requirements in community program RFP's has been delayed because of legal issues, including some resistance to nonprofessional evaluators conducting environmental surveys in community residences. Many individuals including DMH staff, consumers, and family members have expressed concern about conducting unannounced site visits in peoples' homes. A task force including consumers and family members is reviewing the citizen monitoring process to make recommendations regarding implementation of citizen monitoring in community residences. It is anticipated that a citizen monitoring protocol for community residences will be completed during FY'93.

B. Planning

Base Year:

- DMH was re-organized after a legislatively designed split with the Department of Mental Retardation in 1986, implementation, which began July 1, 1988, refocused the agency's mission and planning on individuals with long-term and seriously mentally illnesses

Most Recently Approved Plan (September, 1991):

- Incorporate psychosocial rehabilitation into DMH programs.
- Involve consumers as stakeholders.
- Establish participatory process to: refocus planning on development of public managed care; expand/restructure the community service system through the development of the CCSS design; pilot three to five Local Mental Health Authorities (LMHA) by the end of FY'92; consolidate/close state hospitals; privatize certain inpatient services; and expand opportunities for consumers, family members, advocates and minority groups to participate in DMH planning activities.

Revised or Additional 1992 Goals:

- Revise LMHA goal: relook at the role and functions of the nine DMH Area offices. Devise a plan to maintain the offices as DMH administrative entities that incorporate the LMHA principles of blended funding and protecting the service system from political shifts (Spring, 1993).
- Establish Office of Policy and Planning in FY'92.
- Propose Forensic Mental Health planning initiatives (see details under Current Implementation)

Current Implementation/Accomplishments:

- A DMH Office of Policy and Planning was established in February, 1992.
- A Policy and Planning Committee (including senior staff from all DMH divisions - field and Central Office) meets weekly. They forward policy recommendations to Executive Staff
- DMH provided technical assistance to the Governor's Special Commission on Consolidation of Health and Human Services Institutional Facilities regarding future use of the state operated community mental health centers and the future of the Gaebler Children's Center.
- DMH closed two of its seven adult state hospitals in FY'92 and has phased down a third which will close during FY'93. The Gaebler Children's Center closed in September, 1992
- DMH sent out an RFP to privatize most acute care for DMH priority clients. Fifty-two proposals were received and reviewed by DMH staff, consumers, family members and other interested parties in each affected Area
- DMH implemented contracts with three hospitals to provide acute replacement units for DMH priority clients during FY'92 and is negotiating for others to come on line during the next two fiscal years DMH transferred 160 continuing care patients from Danvers State Hospital (now closed) to five new mental health units at Tewksbury Public Health Hospital in June, 1992

- Statewide workgroups comprised of all stakeholders in the mental health system met during Fall, 1991 and recommended CCSS standards for policy implementation that resulted in a "Guidance Manual for Area Participatory Planning." The two workgroups were: **Facility Consolidation** (sub-groups included: Homeless Mentally Ill, Future of State Hospitals, Monitoring of Placements/Transfers, Privatization of Acute Care, Forensics) and **Managed Care** (sub-groups included: Services and Supports, Administrative Issues, Quality Management, Consumer and Family Participation).

- Several groups emerged from the Participatory Planning Process:

- A Mental Health Advocates Group: leading consumer and family advocates and directors of advocacy and professional organizations meet monthly with Commissioner to review issues and air concerns.

- *Multi-Cultural Advisory Committee*: addresses the need for increased access to services for cultural and linguistic minority groups.

- *Academic Affiliates*: assesses potential collaborations with DMH in education, training, evaluation and research.

- *Consumer and Ex-Patient Advisory Council*: a 19-member statewide group with 19 alternates, selected by lottery in April, 1992 from more than 200 nominees, meets monthly.

- *A Business Advisory Council* assists in: the development of best practices for DMH non-profit vendors and consumer-run businesses; the expansion of competitive employment for consumers in light of the Americans with Disabilities Act; the expansion of areas for public/private partnership and philanthropic fundraising.

- *A Task Force on Services to Sexual Minorities*: identifies needs, preferences and service models for consumers who have alternative sexual orientations.

- Training of (9) local, Area based planning committees regarding CCSS planning occurred in March, 1992.

- Area planning committees identified natural service areas, the geographic basis for development of CCSS's; recommendations were approved by the Commissioner in August, 1992

- A task force on LMHA's has been meeting to consider models. A RFP for a Mental Health Systems Project was issued in October, 1992 to assist the Metro Boston Area in developing its Comprehensive Community Support System(s). Proposals are due in December.

- Future of State Hospitals sub-group will identify needs regarding intermediate and continuing care. Their recommendations regarding the number and structure of facilities and special populations to be served were made to the Commissioner in December, 1992

- The Division of Forensic Mental Health (DFMH) submitted a workplan to the Commissioner in December, 1991 including the following priorities in addition to inpatient, court and jail-based forensic evaluation and screening services they provide currently: develop a centralized clinical consultation capacity regarding forensic patients; develop a legislative proposal for a conditional release system; develop a forensic inventory and data base; develop forensic (secure) inpatient regulations; expand DMH secure capacity; privatize the Bridgewater Treatment Center (BTC); and advocate for legislation to transfer authority for the BTC to the Department of Corrections. Implementation of these initiatives is underway; completion is subject to FY'93 supplemental budget decisions and other actions by the legislature.

Comparison with Base Year:
Planning in 1987 focused on implementation of the Mental Health Action Project and the Governor's Special Message on Mental Health to: provide comprehensive emergency and support services for all chronically mentally ill persons in the Commonwealth, improve inpatient care at state hospitals including substantial capital investment, create 2500 new housing units, and improve DMH management. Budget cuts hastened the need to move more quickly to a community based system and decrease reliance on antiquated and costly state hospitals.

The evolution of planning at DMH has resulted in processes that enabled the Department to begin CCSS planning, integrate forensic planning, close two hospitals (and most of a third), begin to privatize all acute inpatient care, bring 543 new units of housing on line with FY'92 budget resources, and plan for the future use of certain state operated community mental health centers. Increased participation by stakeholders, particularly consumers, has been dramatic. Furthermore, persons of color were more actively involved in the planning process and plans to incorporate and integrate minority groups into the overall planning and implementation process were put in place.

Supporting Narrative:

Upon taking office in January, 1991, Governor Weld convened a Special Commission to consider the future of state facilities. In June, 1991 the Commission recommended the closing of nine state facilities including three DMH hospitals, but delayed its recommendations regarding the CMHC's and the Gaebler Children's Center until April, 1992, pending further study. In order to implement the directives of the Governor's Commission and the goals articulated in the September, 1991 Addendum to the May, 1991 State Plan, DMH Commissioner Elias initiated a comprehensive participatory planning process and established the Office of Policy and Planning to integrate the Department's planning initiatives, particularly Public Managed Care and the development of Comprehensive Community Support Systems.

The Participatory Planning Process initiated in October, 1991 built effectively on: the 1987-88 transition planning to create the "new" DMH; the 1988-89 experience involving consumers, advocates, family members and mental health professionals that culminated in the development of a policy on "priority clients", and 10 public forums during 1989-90 organized under the auspices of P.L.99-660, involving 1300 people, that gathered information and feedback on the current mental health system. One principal outcome of the forums was the desire on the part of participants - consumers, family members, and other stakeholders - for more active participation in planning, program development and program operation.

Unprecedented participation of consumers in the planning process has occurred. All of the statewide workgroups and Area planning committees include significant numbers of consumers and family members. Consumer focus groups were established in September, 1992 and will be completed by January, 1993 to solicit targeted input to CCSS planning based on consumer preference.

In July, 1992, the Participatory Planning Process was linked formally with the Office of Policy and Planning and with Program Operations. Workplans for CCSS Planning and Public Managed Care were developed Weekly meetings of the Area Directors (Program Operations) and the Policy and Planning Committee are held to coordinate the planning of CCSS development and to further the goal of achieving a flat table of organization of Central Office and the field. Citizen participation in Area planning will continue throughout 1992 and 1993. The expected outcome is a set of recommendations to Area Directors and a multi-year Area Plan for each Area by summer. The Area Plans will be integrated into a new State Plan by December, 1993 and the structure of the Area planning committees and their role in CCSS planning and implementation will be formalized and integrated with the state level Mental Health Planning Council.

The Statewide Advisory Council, Policy and Planning Committee and statewide Planning Council include members of the Multi-Cultural Advisory Committee.

C. Consumer and Community Involvement

Base Year:

- Minimal statewide consumer participation in DMH activities.
- Minimal involvement in planning and program development by multicultural and linguistic minority groups.

Most Recently Approved Plan (September, 1991):

- Develop an Office of Consumer Relations within DMH (FY'92).
- Provide training and technical assistance within DMH and in the community at large through the DMH Office of Multi-Cultural Services and the Refugee Assistance Program.

Revised or Additional 1992 Goals:

- Expand activities for the Office of Consumer and Ex-Patient Relations (OCER) (FY'92)
- Re-activate P.L.99-660 Minority Access sub-committee (FY'92). Expand access to mental health services for people of color and cultural and linguistic minorities (ongoing)

Current Implementation/Accomplishments:

- Established the Office of Consumer and Ex-Patient Relations in FY'92.
- Statewide Consumer and Ex-Patient Advisory Council was established with 19 members and 19 alternates. Membership categories were determined through five consumer meetings around the state and include 9 Area representatives, 5 at-large representatives, two seats for elder

consumers, two seats for adolescent consumers and a seat for a parent of a child 12 years or under. Council membership includes physically disabled, cultural, linguistic and sexual minority representation. It meets monthly. A two-day retreat on organizational development was conducted by consumer trainers on 9/3 and 9/4/92.

- First Director of OCER was hired in March, 1992 through a Search Committee with 3/4 consumer membership. He chose to return to his previous Area-based DMH position in July and the search began for a new Director. An Interim Director is in place during the search for a new Director.

- A Mental Health Discrimination Law Project was established in collaboration with the Massachusetts Commission Against Discrimination with a full-time attorney devoted to mental health consumers who are victims of discrimination in housing, employment, education and public accommodation and a consumer advisory council. The attorney also provides Area-based training for consumers in legal protections against discrimination.

- An 800-telephone line is operating.

- A full-time Consumer Information and Referral Specialist responds to inquiries and complaints by consumers and contributes to system accountability. Resource and referral data will be compiled by January, 1993.

- In order to meet the goal of building the capacity of consumers to develop provider organizations, $75,000 in seed grants were awarded, accompanied by training in small business practices and procedures for incorporaton as a non-profit corporation.

- On-going Area-based consumer training is established. First round educated consumers on the CCSS and ways to get involved in the planning process. 740 consumers participated in nine trainings. Second round began in September, 1992 and consisted of focus groups on issues of consumer preference derived from a statewide survey completed in the Fall of 1991 A standard consumer preference instrument will be developed from this process which will be used as a Quality Management tool in conjunction with annual reviews of Program Specific Treatment Plans and Individual Service Plans.

- Consumer Satisfaction instrument was developed by consumers and is included in standard contract for acute replacement units in general hospitals Consumer training team is being organized for comprehensive training initiative for all DMH and vendor staff. Pertinent portions of the Core Curriculum (see Requirement #5 - Training) will be developed by consumer consultants

- OCER publishes a bi-monthly Newsletter.

- Consumers participate on every DMH board, committee and task force.

- Affirmative Action and Reasonable Accommodation strategies are being developed collaboratively by OCER and the DMH AA/EEO Office.

- Two additional DMH Central Office positions were recently filled by consumers plus two Supported Employment positions.

- Two statewide meetings were convened to explore minority concerns. As a result, the P.L.99-660 Minority Access sub-committee was expanded to a statewide Multi-Cultural Advisory Committee (MCAC) to impact CCSS planning. There are 125 members.

- Seven MCAC focus teams reflecting cultural, linguistic and geographic areas initiated planning activities. The teams correspond to the CCSS but are specific to consumers of color.

Comparison with Base Year:
There was substantial growth in consumer participation in all facets of the mental health system and concomitant expansion of consumer influence and expectations. There was increased involvement of a diverse cross-section of the mental health community in planning and program development and steps taken toward the removal of barriers to a fully accessible system.

REQUIREMENT #II: The State plan shall contain quantitative targets to be achieved in the implementation of such system, including numbers of individuals with serious mental illnesses residing in the areas to be served under such system.

Determining the number of individuals in need of public mental health services for planning and service delivery purposes, and the proper targeting of an appropriate array of services to meet the articulated needs of eligible clients, requires sophisticated methods of assessing prevalence and incidence, and efficient and coordinated management information systems. DMH has utilized a nationally recognized methodology for determining prevalence and incidence but has lagged in its development of state of the art management information systems that can track service utilization and outcomes, and produce an unduplicated count of clients using DMH services. In previous years, MIS development was focused primarily on revenue generating activities such as case management and rehabilitation services. The Department has chosen **Quantitative Estimates of Target Population, Targeted Population to be Served,** and **Management Information Systems** as the indicators to demonstrate implementation of this Requirement.

A. Quantitative Estimates of Size of Target Population

Base Year:

- No quantitative estimates of need. Massachusetts used a needs assessment based on social indicators, conducted in 1984, to estimate relative levels of need among Catchment Areas.

Most Recently Approved Plan (September, 1991):

- Utilize Prevalence Estimates of the number of priority clients in each Catchment Area. DMH estimates that 44,207 adults are severely disabled by mental illness and that 22,106 may need public mental health services. This latter group constitutes the Department's planning population.

Revised or Additional 1992 Goals:

- Use Summary Tape File-3 from the 1990 census when it becomes available to recalculate Area Prevalence Estimates to reflect demographic patterns consistent with the most current population count (October 1, 1993).

Current Implementation/Accomplishments:

- Area Prevalence Estimates were developed in 1990, using an NIMH technical assistance grant, to specify the total number of persons with serious mental illness and the proportion targeted for services. These numbers are widely used throughout DMH for planning and evaluating services.

Comparison with Base Year:
DMH successfully implemented Prevalence Estimates into its planning and operations. This step moved needs assessment in Massachusetts from general, abstract concepts of relative need to specific estimates of the number of persons in each geographic area in need of services, based on state-of-the-art estimation methodologies.

Supporting Narrative:

The Department has used Prevalence Estimates of the number of individuals in need of DMH services for planning and monitoring service use since 1990. The estimates were developed with the assistance of Dr. James Ciarlo, through a NIMH technical assistance grant. Since then, these numbers have been used in a variety of applications.

B. Targeted Population to be Served

Base Year:

- No comprehensive client information system was in place to provide adequate data on the numbers of clients served in the categories of service. Measurement was directed primarily at inpatient utilization and the number of residential beds.

  Average Daily Census: 2,399
  Number of Admissions: 9,798
  Unduplicated count of clients served in inpatient facilities: 9,040
  Number of community residential beds: 1,200

Most Recently Approved Plan (September, 1991):

- Reduce inpatient system funding; expand community services. Close three hospitals, redirect resources to community system (FY'92-FY'93).

- Establish comprehensive data base to yield an unduplicated count of clients served in all service components, beyond current ability to count case managed clients who are enrolled in the Client Tracking System (July 1, 1994).

- Provide needed mental health services to all members of the DMH planning population who have additional or special needs in conjunction with those associated with mental illness such as the deaf and hard of hearing, mentally ill substance abusers, elders, AIDS or HIV+, homeless, and cultural and linguistic minorities (ongoing).

- Use the CCSS planning process to plan appropriately for the needs of special and sub-populations (October 1, 1993).

Goals for Special/Sub-Populations:

Deaf and Hard of Hearing

- Increase inter-agency collaboration to plan for future needs of the deaf and hard of hearing seriously mentally ill.
- Increase efforts to address case management needs of deaf and hard of hearing clients.

	TOTAL DMH PLANNING POP.	DMH PLANNING POP. WITH HEARING IMPAIRMENTS
Western Mass.	3058	270
Central Mass.	2447	215
Merrimack Valley	788	160
North Shore	2215	195
Metro West	1987	175
Metro South	2036	180
South West	2007	180
South Shore	2095	185
Boston	4473	400
	22,106	1,960

Mentally Ill Substance Abusers

Note: DMH does not consider this population "special" in that it estimates at least 50% of the target population falls into this category. However, it is recognized that the additional issue of substance abuse requires an additional focus in the provision of services.

- Increase collaboration with the Department of Public Health.
- Increase services for the dually diagnosed.

	TOTAL DMH PLANNING POP.	EST. NUMBER WITH CO-OCCURRING SUBSTANCE ABUSE DISORDER
Western Mass.	3058	1530
Central Mass.	2447	1225
Merrimack Valley	1788	890
North Shore	2215	1105
Metro West	1987	990
Metro South	2036	1020
South West	2007	1005
South Shore	2095	1045
Boston	4473	2245
	22,106	11,055

Elders

- Identify gaps in existing service system for seriously mentally ill elderly DMH priority clients
- Ensure that emergency services, case managers, home care providers, nursing homes and hospitals receive appropriate consultation and training regarding services for elderly consumers.
- Work with the Elderly Mental Health Task Force of the Legislature and the Executive Office of Elderly Affairs to plan and coordinate mental health services for elderly consumers.

	TOTAL DMH PLANNING POP.	EST. NUMBERS OF ELDERS(>65) NEEDING PUBLIC MENTAL HEALTH SERVICES
	Total	**65+**
Western Mass.	3058	558
Central Mass.	2447	446
Merrimack Valley	1788	326
North Shore	2215	363
Metro West	1987	404
Metro Boston	4473	816
Metro South	2036	371
South West	2007	366
South Shore	2095	382
	22,106	4,032

Revised or Additional 1992 Goals:

- Goals remain the same for all populations. Timetable is adjusted to incorporate CCSS planning process currently underway. A new DMH State Plan and targets should be completed by December, 1993. Given the Department's awareness of the high prevalence of substance abuse among the seriously mentally ill, it is recognized that all service components within the system must be capable of addressing the substance abuse treatment needs of DMH clients

Current Implementation/Accomplishments:

Average Daily Census: 1,562
Number of Admissions: 6,163
Unduplicated count of clients served in inpatient facilities & 16
Residential beds: 4,095.

- Two hospitals, Metropolitan and Danvers, were closed in FY'92; the third, Northampton, will close in May, 1993. The Department is doing extensive tracking of clients.

  Of the patients discharged or transferred from Metropolitan: 40 were discharged to community settings of whom 28 remained at the same setting 90 days later, 6 had moved, 3 had "status unknown" and 3 were re-admitted; 90 weredischarged to DMH residences of whom 82 remained there 90 days later, 2 moved to another setting, and 6 were re-admitted, 37 were discharged to other facilities of whom 6 remained in the same setting 90 days later, 19 had moved, 2 had "status unknown, and 10 were re-admitted; and 97 were transferred. Discharge destinations/other facilities included: community living alone, with family and with non-family; private hospitals, nursing homes, correctional facilities, VA hospitals, DMR facilities, detox facilities, and other state hospitals.

  Of the patients discharged or transferred from Danvers: 126 were discharged to community settings of whom 85 remained at the same setting 90 days later, 28 had moved, 8 had "status unknown", and 5 were re-admitted; 115 were discharged to DMH residences of whom 98 remained there 90 days later, 14 had moved, 1 had "status unknown", and 2 were re-admitted, 25 were discharged to other facilities of whom 16 remained at the same setting 90 days later, and 9 had moved; and 154 were transferred. Discharge destinations included the same as above

  Of the patients discharged or transferred to date from Northampton: 105 were discharged to community settings of whom 67 remained at the same setting 90 days later, 28 had moved, 6 had "status unknown", and 4 were re-admitted; 97 were discharged to DMH residences of whom 78 remained there 90 days later, 11 had moved, and 8 were re-admitted; 45 were discharged to other facilities of whom 12 remained at the same setting 90 days later, 24 had moved, 8 were re-admitted, and 1 had "status unknown"; and 2 were transferred. Discharge destinations included the same as above.

- 490 community residential beds were added in FY'92. 53 additional beds were brought on line by Fall, 1992 using FY'92 funds, bringing the total number of beds added to 543

- Expanded day programs, crisis intervention programs and case management services were added to support the residential development necessary to close the hospitals, and expansion of diversionary services, emergency services and case management is underway.

- CCSS Area planning, to be completed by Summer, 1993, will enable DMH to establish reliable targets. In terms of the actual number of the target population being served, DMH does not yet have clear data pertaining to non-case managed clients.

- In the Spring of 1993, a needs assessment survey of the entire state will be completed by DMH Results will provide information regarding service need for special and sub-populations including the deaf and hard of hearing, the elderly and the dually diagnosed In FY'92, approximately 150

deaf or hard of hearing individuals utilized interpreting services funded by DMH. DMH and DPH are completing a joint survey of (DMH & DPH) programs throughout the state in order to assess the number of dually diagnosed individuals currently being served and to identify service gaps. The results will be used for joint program planning efforts as well as for aiding in decisions about resource reallocation within DMH.

Comparison with Base Year:
Significant expansion of community-based services occurred between 1987 and the present time in spite of significant budget cuts.

Supporting Narrative:

The CCSS planning process currently underway includes an extensive needs assessment, scheduled for completion by June 30, 1993, followed by a participatory process which will identify service system gaps and strategies to fill those gaps, as much as possible, through redeployment of base resources. Those plans are expected to be completed by Summer, 1993. When CCSS planning is completed, implementation will begin. It is anticipated that the redeployment of hospital dollars will enable DMH to expand its community-based system. It is further anticipated that CCSS planning will further expand services by shifting community resources, wherever possible, to less restrictive and less costly program types. The reorganization of the service system is expected to be a multi-year process, leading to implementation of a new system of care from which the target population will continually benefit.

C. Information Systems or Management Information Systems

Base Year:

- Statewide inpatient database (MFR) based on manual facility reports. No statewide data on community services.

Most Recently Approved Plan (September, 1991):

- Convene an Information Systems Planning Task Force .
- Integrate MFR with the Client Registry.
- Implement facility-based inpatient information system.
- Create a mainframe client tracking system.

Current Implementation/Accomplishments:

- Systems Planning Task Force issued a final report endorsing plans for mainframe client tracking system.
- MFR in place with improved format, electronic submission from all large facilities, and merged centrally with Registry for analysis.
- TRACE (an inpatient client tracking system) was implemented at two hospitals and underway in a third; funding was received for remaining hospital and three CMHC's.
- PC-based Client Tracking System in place for case managed clients.

Comparison with Base Year:
Inpatient data is vastly improved.
Service utilization data is available for case managed clients.
Placement data is available for residential services.
Plan is in place to address remaining gaps in data management system.

Supporting Narrative:

Over the last five years, DMH has dramatically improved its client information. In 1987, statewide client data was limited to an underutilized inpatient database, maintained by manually entering paper reports from facilities. There was no statewide information system for any other service.

Today, DMH has a much improved inpatient database which is heavily used for decision support, a statewide Client Registry containing all persons receiving case management and residential services, and a detailed tracking system for case managed clients. These systems provide data for a number of other special-purpose databases, including tracking of patients awaiting community placement and monitoring patients up to 90 days after discharge. Standards developed for these systems, particularly the DMH unique client ID, are beginning to be used in the numerous local client systems. The major initiative now is to develop a statewide, on-line system containing demographic and utilization information on all persons served by DMH. This system will complete the process of expanding the client coverage of DMH information systems and will also reduce duplication by integrating existing systems

REQUIREMENT #III: The State plan shall describe available services, available treatment options, and available resources (including Federal, State and local public services and resources and to the extent practicable, private services and resources) to be provided to individuals with serious mental illnesses.

The Department provides, in its own programs and facilities and through an extensive network of contracted programs, an array of services to meet the needs of individuals with serious mental illnesses, including both mainstream and specialized service models for those with specialized service needs. The inpatient and community privatization and public managed care initiatives, and collaboration with Mental Health Management of America, Inc., the state Medicaid agency's vendor for mental health and substance abuse services, have positioned DMH to capture federal and private dollars. Through Comprehensive Community Support System planning and implementation, DMH plans to identify and eliminate barriers to accessible care and to significantly increase both access to and availability of emergency, treatment and rehabilitation services. In addition to designing a service system for the majority of its targeted adult planning population, particular attention has also been focused on planning appropriate and accessible services for the homeless, deaf and hard of hearing, dually diagnosed, cultural and linguistic minority groups, elders and those with AIDS or HIV+ as well as those who need emergency or forensic mental health services. DMH has also made a strong commitment to ensuring that in both DMH-operated and vendor-operated inpatient and community programs, the human and legal rights of all clients are protected. The Department has chosen **Increased Access to Services, Access to Services for Special and Sub-Populations,** and **Protection and Advocacy** as the indicators to demonstrate implementation of this Requirement.

A. Increased Access to Services

Base Year:

- 3,565 clients receiving case management services; 119 case managers
- 1,200 beds in residential programs
- $0 in funding for clubhouses
- $0 in funding for social clubs
- Emergency services complete (24 hr, 7 day) in 13 of 40 Areas
- Inpatient Average Daily Census = 2,399

Most Recently Approved Plan (September, 1991):

- Increase number of clients receiving case management services; hire additional case managers.
- Increase community residential beds.
- Increase funding for clubhouses and social clubs.
- Complete emergency services system (24 hr, 7 day) in all 9 Areas (1990 re-organization reduced the number of Areas from 40 to 9).
- Reduce Inpatient Average Daily Census.
- Bring 500 beds in private and general hospitals on line for use by DMH priority clients, and transfer provision of acute care for adults from state-operated to private and general hospitals (FY'92).

Revised or Additional 1992 Goals:

- On July 1, 1992 Mental Health Management of America, Inc. (MHMA) took over management of mental health and substance abuse services for eligible Medicaid recipients. this includes contracting for a continuum of sevices including some (but not all) acute inpatient care, that Medicaid recipients receive. Because a significant number of DMH priority clients are Medicaid eligible, the Department is collaborating aggressively with MHMA to:

  - develop a working agreement to ensure that mental health services and programs contracted for by MHMA meet agreed upon standards and provide access to DMH priority clients (completed, November, 1992);

  - develop joint standards to govern emergency screening, admissions, diversionary programs, etc. for all Medicaid recipients (by June,1993);

  - develop additional community-based hospital diversion services (October 1, 1993).

  - determine the appropriate number of psychiatric beds needed to come on line in private and general hospitals (in addition to DMH replacement units) and select hospitals with existing secure inpatient units as MHMA network providers that can appropriately serve DMH priority clients (October 1, 1993).

Current Implementation/Accomplishments:

- 7,111 clients currently case managed. Over 13,000 since 1987. 413 case managers, with vacant positions currently being filled. 35 new case managers were hired in FY'92.
- 4,095 beds in residential programs
- 37 clubhouses, $13.5 million for funding clubhouses in all Areas
- $1.5 million for funding social clubs in six of nine Areas
- Emergency services network complete (24 hr, 7 day) in every Area
- Inpatient Average Daily Census = 1,325

- 46 medical/surgical beds were converted to psychiatric beds, accessible to DMH priority clients through the DPH/DMH collaborative DoN process, since 1989. 200-300 psychiatric beds in private and general hospitals came on line between FY'89 and FY'92.

- Through DMH's 1991 RFP process to privatize acute care, approximately 300 inpatient beds will be available to DMH priority clients over the next two fiscal years in units that operate under contract to the Department. This will include acute care statewide, and intermediate and continuing care in the Western Mass, and Metro Boston Areas. As a result of the process, 62 acute replacement beds became operational in FY'92 and 32 additional acute replacement beds came on line in July, 1992. Approximately 178 additional acute and continuing care beds in private and general hospitals are expected to become operational during FY'93 in the Merrimack Valley, Western Mass, Metro Boston, Central Mass and Metro West Areas.

Comparison with Base Year:
DMH made substantial progress in increasing access to community based services and reducing the level of reliance on inpatient care. At the same time, the Department has taken steps to ensure appropriate access to high quality inpatient care when necessary.

Supporting Narrative:

Over the past several years, Massachusetts has maintained a strong commitment to decreasing the use of inpatient care and increasing the use of integrated, community based services. The results of this commitment are striking.

The Massachusetts Average Daily Census has dropped by more than 1,000. As DMH continues to reduce the numbers of state operated inpatient facilities, the census is expected to drop further.

At the same time, community based services are expanding. Core community services, such as case management, emergency, residential services and day programs, have increased dramatically. Under the philosophy of psychosocial rehabilitation, community based rehabilitation and support services are the preferred alternative to institution-based care. In addition, club houses and social clubs, which were virtually non-existent several years ago, have become integral components of the service system.

It is true, however, that severe budget cuts and subsequent staffing changes caused by "bumping" over two recent years decreased access to community services such as outpatient treatment. This created difficulties as DMH closed two hospitals and relocated clients from institutional to community settings. With the reallocation of inpatient resources to community programs, DMH intends to maintain access to community services.

DMH performs a 90-day and one-year follow-up for all clients discharged from state hospitals, CMHC's or replacement units to determine tenure success rate. The one-year community tenure in September, 1992 was 62% compared to 58% in September, 1991.

B. Access to Services for Special and Sub-Populations

Base Year:

- Improve access to existing mental health services for seriously mentally ill individuals with specialized service needs, including those who are deaf, hard of hearing, medically ill, members of cultural/linguistic minorities, elderly, young adults, forensic clients, those with mental retardation, and those who abuse substances (dually diagnosed);

- Work with the Department of Mental Retardation (DMR) to find appropriate placements for mentally retarded individuals who were inappropriately housed at the Department's inpatient facilities by 6/30/90;

- Continue discussions with DPH and initiate an NIMH grant to look at inpatient care of persons who are dually diagnosed;

- Prepare individual service plans for each of 353 Mentally Ill/Medically Involved (MI/MI) individuals residing in DMH facilities, as required by legislation, to guide more appropriate placement

- Open specialized mental health units in county correctional facilities, as authorized by 1987 legislation.

- Appoint a statewide AIDS coordinator.

- Provide consultation on AIDS and HIV issues to DMH and provider agencies.

Most Recently Approved Plan (September, 1991):

- Continue to institutionalize efforts to reach out to populations with specialized service needs, build upon existing efforts to provide in-service training for mental health staff, and increase advocacy efforts within these constituency groups. Encourage local Areas to involve representatives from these groups in the planning and development of the mental health service system. As additional resources become available, develop specialized services

- Place remaining 46 DMR clients out of (DMH) inpatient facilities as part of a legislatively funded initiative With DMR, develop process to identify DMR clients inappropriately placed in DMH community residences and move them, when appropriate, into DMR programs (FY'92)

- Plan jointly with DPH regarding needs of MI/MI individuals to develop 160 community residential beds, enhanced medical care at DMH facilities, and development of nursing home mental health resource teams

- Institute a NIMH grant to: survey the extent of the dual diagnosis problem in the seriously mentally ill in Worcester State Hospital, looking at prevalence and incidence, develop treatment

techniques and evaluate the effectiveness of adding drug abuse and alcohol treatment services to standard psychiatric treatment of 100 seriously mentally ill state hospital patients with co-occurring alcohol/drug abuse disorders.

- Establish workgroup comprised of mental health and substance abuse professionals to focus on conducting a needs assessment; make recommendations to DMH on strategies for responding to the complex needs of this population.

- Recruit and retain multi-cultural staff.

- Increase access to services for mentally ill and emotionally disturbed individuals involved with the criminal justice system.

- Continue to provide mental health care for priority clients with AIDS or HIV+. (The Department of Public Health has primary responsibility for planning a service system for people with AIDS.)

- Address policy and programmatic issues related to AIDS within the DMH population to ensure access, including extensive training for staff on AIDS and AIDS education and adopting universal precautions in all inpatient facilities.

- Compile a resource guide to identify and describe services for elderly consumers in each Area.

- Address training needs of case managers and other DMH staff who work with elderly consumers in the community.

- Open a specialized 22-bed evaluation unit for elders at Westborough State Hospital.

- Place long-stay elderly consumers from state hospitals in appropnate community settings, resources permitting.

Revised or Additional 1992 Goals:

- Incorporate the needs of special and sub-populations in the Area needs assessments completed as part of the CCSS planning process (October 1, 1993).

- Aggressively place MI/MI individuals in appropriate settings. Plan for remaining, difficult to place, clients who have more intense behavioral issues (FY'92/'93).

- Use outcome from previously funded NIMH grant re: dually diagnosed individuals to apply for two NIMH grants to continue the development of treatment techniques for (1) dually diagnosed persons who are inpatients, and (2) dually diagnosed persons who are homeless (through UMass

Medical School and several homeless shelters in Boston and Worcester) (FY'93).

- Establish a permanent mechanism to monitor the operations of private agencies and organizations who have contracted with DMH to ensure that the cultural and linguistic needs of DMH priority clients are being met (October 1, 1993).

- Review DMH regulations, operational policies and practices, and all RFP's, to ensure compliance with the Americans with Disabilities Act of 1990 (October 1, 1993).

Current Implementation/Accomplishments:

- Formed a Deaf and Hard of Hearing Mental Health Advisory Committee which includes: Massachusetts Commission for the Deaf and Hard of Hearing staff, consumers, DMH staff, and mental health professionals specializing in deaf services. Meets at least once a month to address access issues and make recommendations to DMH.

- Advisory Committee developed a document outlining principles for achieving communication access for deaf, late deafened and hard of hearing people in DMH programs including the inpatient Unit for Deaf and Hard of Hearing clients at Westborough State Hospital. Document was accepted by DMH and incorporated into the "Guidance Manual for Area Participatory Planning" (March, 1992). The Department mandate is for adherence to the principles as the CCSS's are developed.

- Individuals interested in mental health services for deaf and hard of hearing mentally ill were contacted and encouraged to participate in Area participatory planning.

- In February, 1992, DMH re-issued the referral procedure for its statewide inpatient unit (for deaf and hard of hearing) to all emergency services providers to enhance access to the unit.

- DMH continues to make available its Community Mental Health Services for Deaf and Hard of Hearing Persons Resource Directory (June, 1990) as part of the effort to ensure access.

- In January, 1992 DMH and New England Telephone Company collaborated on an updated TTY directory.

- The DMH Director of Special Populations Services works, on an on-going basis, with mental health staff, as well as other state agencies, to assist DMH in meeting the mental health needs of individuals who are deaf or hard of hearing and seriously mentally ill

- DMH funds Interpreter Services for deaf, hard of hearing and non-English speaking clients to facilitate access to services.

- From September, 1991 to June 30, 1992, 35 DMR clients of the 46 DMR clients that are part of a funded DMH/DMR initiative moved from DMH inpatient facilities to DMR residential programs. With regard to the 11 remaining individuals, either plans are in progress or the current acuity level of the individual's mental illness requires continued inpatient treatment. Funds have been transferred to DMR on a pro-rated basis for care of these clients.

- DMR and DMH identified 49 DMR clients residing in DMH residences. Plans were made for these individuals to begin receiving DMR residential services. Ten of the 49 individuals moved into DMR facilities by June 30, 1992. Funds were transferred to DMR on a pro-rated basis. The remaining 39 have plans which are in various stages of development and implementation. On July 1, 1992 DMR assumed fiscal responsibility for all 49 of the individuals.

- 80 MI/MI individuals remain in DMH facilities. Placements of others have been made to DPH facilities, and for patients able to pass an OBRA/PASSAR screen, to nursing homes and specialized long-term care facilities contracted for by DMH (e.g. Farren Care Center)

- An NIMH grant to compare the relative effectiveness of relapse prevention and psychosocial rehabilitation techniques for the dually diagnosed seriously mentally ill (see description above) enabled DMH to work intensively with 100 clients at Worcester State Hospital to receive diagnostic and therapeutic services they otherwise would not have received. The treatment techniques derived from this study are being used to upgrade alcohol and drug abuse treatment services as delivered by case managers. The earlier component of the study, a survey, found that approximately 60% of DMH inpatients met the criteria for substance related disorders and supported the need for specialized services for this population. This represents approximately 1,000 DMH (in)patients.

- The dual diagnosis workgroup continues to meet monthly. Recommendations regarding dual diagnosis programming were completed in November, 1991 and were included in the "Guidance Manual for Area Participatory Planning" (March, 1992).

- The DMH and DPH Commissioners met in June, 1992 and developed a plan aimed at greater collaboration between the two agencies in an effort to enhance access for the dually diagnosed population. The plan includes:

a) *Completion of a joint survey of programs to determine current level of collaboration, extent of current services for the dually diagnosed, and gaps. Expect completion in January, 1992*

b) *Development of pilot programs aimed at improving access by providing additional, needed services (Specifics will be dictated largely by survey results)*

c) *Joint sponsorship of a dual diagnosis conference during 1993 to enhance access through training and networking.*

d) *Development of an affiliation agreement.*

e) *DPH involvement in Area Participatory Planning. DPH has identified interested staff/providers.*

- Certification of inpatient beds at four state hospitals and four CMHC's enabled DMH to comply with Section 504 of the Rehabilitation Act of 1973 and Title VI of the Civil Rights Act of 1964, as amended, with specific emphasis on the mandate to meet the needs of populations with cultural and linguistic needs.

- DMH expanded services in the community to meet the needs of cultural and linguistic minorities (see specifics in Narrative).

- DMH convened two statewide meetings in 1992 regarding access to services for the minority community, and expanded the P.L.99-660 sub-committee on Minority Access to a statewide Multi-Cultural Advisory Committee. (See details under Requirement #I/Planning.)

- EEO/AA staff participated during FY'92 in the review of acute hospital and residential services RFP's to ensure consideration of the special needs of culturally and linguistically diverse populations and the specific requirements of the disabled client.

- The DMH Division of Forensic Mental Health (DFMH), functionally integrated within the Division of Program Operations, established mental health services in all county correctional facilities except Barnstable, Bristol and Middlesex. DFMH hopes to expand mental health services to those counties in FY'93. It is expected that a full forensic mental health unit will open in the Hampden County House of Correction in February, 1993, and in the Suffolk County House of Correction in May, 1993. On-site mental health services provide better access to care and reduce referrals to DMH Hospitals and Bridgewater State Hospital, a Department of Corrections facility.

- DMH issued a new AIDS policy in May, 1991 which incorporates the Center for Disease Control's recommendations on AZT (Azidothymidine) prophylactic treatment and mandated training for all staff. The policy is applicable to all mental health facilities and programs operated or funded by DMH. Discrimination against clients based solely on their HIV status is prohibited. If the critena for admission are otherwise met, care and treatment will not be denied. The policy focus is on prevention and education but provides for site visits and case consultation if there is concern about the management of an HIV infected individual. The draft of a revised policy currently under review commits the Department to assess every client in the system for risk; if the client is deemed at risk, then the policy recommends that testing, although still voluntary, should be explored. It is felt this approach would increase opportunities for access to early intervention, care and treatment.

- Coordinators for MI/MI (mentally ill/medically involved) patients are located in each of the Department's inpatient facilities to effect appropriate disposition and placement for these patients

- Area liaison staff are available to provide consultation as requested to nursing homes and elderly housing sites, and to assist with placement of elderly consumers.

- Specialty services operated in all areas of the state specifically for elderly consumers include

Residential:	156 beds
Day Treatment/Activities:	91 slots
Outreach Programs:	@2,832 clients served
Case Management:	401 clients (65+); 295 clients (60-64) (as of 9/30/92)
State hospital inpatient :	22 beds/Westborough; 60 beds/Worcester

In addition, many other elderly consumers receive services from residential, day, outreach and inpatient programs that either serve elderly persons with and without serious mental illness, or serve SMI adults of all ages.

Comparison with Base Year:
Significant steps have been taken since 1987 to improve access to existing mental health services for individuals and populations with specialized needs as evidenced by the planning effort to establish Comprehensive Community Support Systems (CCSS), collaboration with other state agencies, initiation of the Multi-Cultural Advisory Committee, the extension of the mandate to meet requirements for services to cultural and linguistic groups to hospitals and agencies contracting to provide services, and enhancement of community-based residential services.

Supporting Narrative:

Both access to services and more appropriate programming for all special and sub-populations have been developed.

Plans call for continued efforts to place the remaining DMR clients who are in DMH settings into DMR programs, with the goal of more appropriately meeting their needs and creating openings in DMH funded programs for consumers of DMH services.

Since the MI/MI population was first assessed in 1987, almost 90% have been discharged to community settings or placed in more appropnate, medically oriented institutions. Currently, fewer than 5% of DMH inpatients can be identified as MI/MI individuals.

The Department currently has a contractual agreement with a specialized long-term care facility - the Farren Care Center. 90% of the 77 contracted beds are filled at all times and some of those clients have been discharged to even less restrictive settings. During CCSS planning in each Area, placement of MI/MI individuals is a consideration Some Areas have negotiated supplementary rates with private sector nursing facilitiesin order to place clients.

As identified in last year's Progress Report, there is an issue of additional monies requested by nursing homes for the difficult to manage client, especially the young adult non-geriatnc MI/MI client The state Medicaid rate for nursing homes is currently based on a management minute questionnaire Although that questionnaire accounts for all physical/medical issues, there is general consensus that it does not appropnately account for behavioral issues that might be associated with DMH MI/MI clients The result is

that nursing homes do not feel that they can appropriately staff and handle behaviorally involved MI/MI clients at the MMQ/Medicaid rate. DMH is investigating this situation, including checking other states' experience and comparing rates of Alzheimers patients and seriously mentally ill patients. The outcome of this investigation is uncertain.

DMH also negotiated with DPH to ensure that those MI/MI clients who are appropriate for public health inpatient units are properly assessed and transferred. DMH is working very closely with the two DPH hospitals to establish MI/MI units where DMH clients with serious medical issues can be appropriately served. Each DMH Area has a nursing home liaison and resource team. These teams assist nursing homes on an as needed basis to deal with the psychiatric problems of medically involved individuals. DMH anticipates continuing its relationship with Farren Care Center and there is the possibility that additional negotiations will take place with other nursing homes interested in serving MI/MI clients.

DMH funds and provides interpreter services for clients on DMH inpatient units as well as in some non-acute settings such as day treatment, outpatient, residential programs, and meetings with case managers. Interpreters for the deaf and hard of hearing (150 clients) and for the following number of linguistic minority clients were provided in FY'92: Vietnamese (35), Cambodian (35), Portuguese (13), Spanish (12), Haitian (10), Italian (1), Chinese (13), Albanian (3), Cape Verdean (2), Russian (1), Arabic (2), Japanese (1), Greek (1), and Polish (1). Numbers of clients are approximate, but total expenditures in FY'92 were $36,421 compared to $13,355 in FY'90.

Programs which receive funding through DMH contracts that specifically serve minority populations include:

Metropolitan Indo-Chinese Child and Adolescent Services (Chelsea)
Indo-Chinese Psychiatry Clinic (Boston)
Haitian Mental Health Unit (Cambridge)
St. Ann's Home (Lowell)
South Cove Community Health Center (Boston)
Inquilinos Borecuras en Accion (Boston)
Alianza Hispana (Boston)
Concilio Hispana (Cambridge)
Dorchester Counseling Center (Boston)
Gandara Mental Health Center (Springfield)
Hyland House, Inc. (Fall River)
Roxbury Youth Works, Inc. (Boston)
South End Community Center (Boston)
Spanish-American Center, Inc. (Leominster)

(See Appendix for details on numbers of clients served.)

C. Protection and Advocacy

Base Year:

- No Central Office human rights staff available to provide any significant support, training or advice to field staff (human rights officers, human rights committees, other staff) concerned about

human rights issues. No statewide conferences or training.

- In 1986, DMH promulgated Regulations (104 CMR 24.00) which set forth guidelines for the investigation of consumer, family or advocate complaints. The Office of Internal Affairs (OIA) was established to oversee the complaint and investigation process.

Most Recently Approved Plan (September, 1991):

- Ensure the human and legal rights of clients in all DMH facilities and programs. A Special Assistant for Human Rights will provide overall coordination of issues and policies related to human rights

- Ensure that any complaint alleging dangerous, illegal or inhumane incidents or conditions will be investigated or otherwise resolved.

Revised or Additional 1992 Goals:

- Extend DMH commitment to ensuring the human and legal rights of clients to privatized acute "replacement" units and all contracted community service programs (FY'92/'93)

- Implement structural changes in the OIA (October 1, 1993).

Current Implementation/Accomplishments:

- The DMH Central Office Special Assistant for Human Rights meets regularly with and communicates often by telephone with inpatient human rights officers to provide them with direction, support and advice. Training is provided informally as well as through statewide conferences twice a year, and through locally based training events. Handbooks were produced and distributed regarding (i) rights of clients in the community, (ii) role and responsibilities of the human rights officer, and (iii) role and responsibilities of a human rights committee Selected human rights issues (such as restraint and seclusion) were investigated and lengthy reports prepared by the Special Assistant for Human Rights. Training and education regarding seclusion and restraint, at the field level, are being implemented as a result of feedback the Department received on these issues from consumers.

- The Protection and Advocacy system maintains its presence in many of the inpatient facilities with space, telephone and access to clients and staff provided by DMH.

- The standard contract DMH developed for private and general hospital "replacement" units calls for the hospital to safeguard the human and legal rights of clients by appointing a human rights officer, establishing a human rights committee, establishing a citizen monitoring program and allowing the Protection and Advocacy system access to clients and staff

- In 1992, the Department conducted a thorough analysis of the complaint/investigation process (OIA) and identified a number of areas which needed strengthening. A new structure and process was initiated which ensures objectivity in the conduct of investigations and the systemic integration of the results of complaint/investigations with quality management, human rights, human resources, fiscal and contracting activities within DMH.

- Management information reports are produced on a monthly basis by OIA to apprise interested persons of the categories of complaints received by the Department and to monitor the timeliness of completion of investigations.

- DMH continues to work collaboratively with the Disabled Persons Protection Commission to ensure that all reporting requirements under M.G.L. Chapter 19C are met, and that allegations of abuse by a caretaker are investigated.

Comparison with Base Year:
Since 1987 DMH increased its training and supervision of human rights officers and human rights committees; expanded its involvement in human rights compliance beyond the hospitals to the entire CCSS; held regular human rights conferences; and prepared reference guides for hospital and community staff regarding the human and legal rights of clients.

As a result of the 1992 reforms, OIA reports directly to the Commissioner. All investigations of complaints by staff, consumers, family members, advocates and other mandated reporters are supervised by OIA and will be conducted by trained investigators who are not affiliated with individual facilities. Previously, investigators were based at each facility where a significant percentage of the complaints originated, some investigations were overseen by the Areas, and not all personnel performing investigations received specialized training.

DMH has taken steps to ensure that decision letters directing corrective action in response to complaints are prepared by DMH Area Directors rather than facility heads or community program directors to reinforce objectivity. These letters are reviewed by Central Office senior management staff to monitor the appropriateness and timely completion of recommended actions and to determine any statewide training and/or policy implications.

In addition, significant outreach is being conducted to ensure that consumers in community-based programs are aware of their rights to file complaints under 104 CMR 24.00.

REQUIREMENT #IV: The State plan shall describe health and mental health services, rehabilitation services, employment services, housing services, educational services, medical and dental care, and other support services to be provided to individuals with serious emotional and mental disorders with Federal, State and local public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

As the Department completes the restructuring of its service delivery system and the implementation of public managed care, it will continue to develop and support an integrated array of programs and services that are designed to enable persons with serious mental illnesses to live and work outside of institutions in communities of their choice. This entails maintaining existing, proven service models and developing new ones that are responsive to consumer need and preference. In the course of closing two state hospitals (and most of a third) and consolidating services in its remaining facilities, DMH developed 543 new community beds and increased day programs, case management, day treatment, supported employment, supported housing and community support programs, with resources formerly tied to those hospitals redirected to supporting consumers in the community to more appropriately serve them and to alleviate waiting lists for services. In addition, DMH has used its CSP grant to do significant outreach and training with consumer groups and has developed systems that enable managers to more accurately track clients in need of particular services. The Department has chosen **Extent and Availability of Services, New Service Programs** and **Other Service Characteristics** as the indicators to demonstrate implementation of this Requirement.

A. Extent and Availability of Services

Base Year:

- Emergency services complete in 13 of 40 Areas.
- 1,200 residential beds. (200-300 in Metro Boston.)
- # Clients/year receiving outpatient services, unknown.
- No funded clubhouses
- No funded social clubs
- 3,565 clients receiving case management.
- 9,040 unduplicated clients served in inpatient facilities.

- Number of supported employment programs, unknown.
- Number of family support programs, unknown.
- # Respite beds, unknown.
- Poor access to medical care for DMH priority clients

Most Recently Approved Plan (September, 1991):

- Complete emergency services in all 9 Areas.
- Fund 9,050 residential beds.
- Fund 44 clubhouses.
- Fund 25 day treatment programs.
- Provide case management services to 22,106 adult clients.
- Operate 2,297 inpatient beds.
- Provide respite bed capacity in all Areas.
- Fund 27 supported employment programs.
- Fund 31 consumer and/or family support programs.
- Create 500 new housing units to accommodate needs of state hospital patients affected by facility closure/consolidation (FY'92).
- Increase the use of non-DMH dollars to develop residential programs for the SMI in Metro Boston; apply for all categories of federal housing and service funds for HMI adults. FY'92 goal: 201 units.
- Cautiously integrate clozapine into DMH facilities; train staff. Use centralized database to determine impact of clozapine on SMI. [Approx. 300 inpatients were receiving clozapine in March, 1991.]

Revised or Additional 1992 Goals:

NOTE: DMH projected the development of 9,050 residential beds in the September,1991 Plan. This projection was unrealistic based upon known appropriation levels and identified, eligible clients. DMH also targeted 22,106 clients to be case managed; also totally unrealistic. Numbers were derived from prevalence estimates of overall need statewide and mistakenly incorporated as target numbers for development.

- Revise Target for residential beds to 3,749 (in FY'92); 4,300 by October 1, 1993

- Revise target for clients receiving case management services to 7,200 based on client eligibility and available resources (by October 1, 1993).

- Determine the availability, gaps and need for specific services in each approved natural service area through the Area Participatory Planning Process. Base design of each CCSS on this assessment and match with available resources to provide at least those services which are determined to be essential to a CCSS. Build on this basic foundation to create the service configuration and capacity for each natural service area (FY'93-'94).

- Develop 79 additional residential beds by October 1, 1993.

- Continue initiatives in Metro Boston to increase number of residential beds including those for the homeless mentally ill. Bring 100 beds on line by October 1, 1993.

- Double the number of DMH inpatients on clozapine trials (FY'92). Integrate clozapine information into the universal Client Registry (FY'93).

Current Implementation/Accomplishments:

- Emergency services are complete in all 9 Areas (27 programs).
- DMH hired 35 new case managers in FY'92; expanded diversionary services; and increased capacity in day programs. 7,111 clients are case managed (9/30/92).
- 32 DMH-funded day treatment programs (as of 9/30/92).
- DMH served 6,506 unduplicated clients in inpatient facilities in FY'92.
- DMH contracts for 57 respite beds <72 hours; 46 respite beds >72 hours
- DMH currently operates 1,302 state hospital beds and 381 CMHC beds
- It is estimated that 77,000 clients/year receive outpatient services.
- DMH currently funds 37 clubhouse programs.
- DMH brought 490 residential units on line in FY'92; an additional 53 beds came on line by Fall, 1992 (with FY'92 funds), increasing the overall number to 4,095 and exceeding the target Included are:

  - 118 supported housing beds.

  - 196 new units of housing in Metro Boston in FY'92, including:

    • 44 units developed with DMH funds reallocated from inpatient hospitals to community housing. (Closing of Metropolitan State Hospital.)

- 66 units developed largely for the HMI using a variety of non-DMH state and federal programs.

- 86 beds for the HMI through a NIMH grant.

- 23 DMH- funded supported employment programs (as of 9/30/92).
- 26 DMH- funded consumer and/or family support programs (as of 9/30/92)
- DMH developed a system to train professional staff in the use of clozapine and is developing a methodology for prioritizing patients for the medication.
- DMH is developing a mechanism to fund the maximum number of patients on clozapine and working with Medicaid regarding payment for outpatient treatment. In the last quarter of FY'92, DMH doubled the number of inpatients authorized to receive clozapine to almost 700.
- The Department of Public Welfare/Medicaid received a waiver in 1992 from the federal government that permits them to enroll most Medicaid recipients in a managed care program to receive general medical care. Recipients may choose to enroll either in an HMO or Medicaid's Primary Care Clinician Program. To ensure access to appropriate medical care, DMH is working with Medicaid on implementation of this program to ensure that DMH clients are appropriately assigned to primary care clinicians who are experienced in treating the medical needs of the seriously mentally ill.
- The Massachusetts Rehabilitation Commission (MRC) received a federal grant ($113,000) in 1992 for each of three years to provide advanced employment opportunities for people with mental illness. The grant was awarded to a newly formed collaborative that includes the Area MRC office, a DMH-funded clubhouse, a day program of a local community mental health center, the DMH Central Mass Area Office and a local college to develop advanced employment opportunities and provide career counseling and referrals.

Comparison with Base Year:

DMH doubled the number of clients receiving case management; completed its emergency services system (statewide coverage); increased the number of supported employment programs; and increased the number of funded clubhouses from 0 to 37.

DMH increased the number of residential units from 1,200 to 4,095. Housing was accomplished through lease arrangements through DMH contracts; leasing newly constructed or rehabilitated state properties, supported housing; construction of HUD 202 and McKinney housing. (There are currently a total of 1,183 residential units in the Metro Boston Area; 406 additional residential units since July, 1987 plus 117 units developed to replace inadequate existing housing.)

DMH went from no experience with the drug clozapine to ranking second in the United States in the use of the drug.

DMH significantly increased the number of respite and holding beds in the community.

DMH increased opportunities for employment of priority clients through transitional and supported employment contracts as well as collaborative efforts with private sector partners.

Supporting Narrative:

A significant number of residential units in Metro Boston were developed with non- DMH dollars. Leveraged non-DMH funds include: HUD McKinney Section 8, HUD McKinney Permanent Housing, HUD 811 Program, the McKinney NIMH Research/Demonstration project and the State Chapter 689 program

DMH collaborates with other agencies to achieve housing goals: Division of Capital Planning and Operations, Executive Office of Communities and Development, Mass Housing Finance Agency, Community Economic Development Assistance Corporation.

DMH has progressed from a very cautious clozapine initiative targeting long-term regressed clients who have not responded to other psychotropic medications to a large scale trial including younger, less regressed clients. Results indicate better than expected results. Approximately one third of patients on clozapine during this trial have shown marked improvements. Virtually all DMH facilities have reported that some patients have improved to the point where they can be discharged to the community. There will be greater understanding of the extent of the impact once the centralized database is in place.

All DMH facilities report additional plans to expand the use of clozapine. DMH has developed alternative follow up systems in every Area and subarea to replace the Caremark, Inc. monitoring system. These alternative systems are working well; no problems identified, no specific patient complaints or incidents noted.

B. New Service Programs or Relations with Other Programs

Base Year:

- Focus of DMH's CSP grant in 1987 was on the development of consumer empowerment groups such as M*POWER and on providing leadership training for consumers. In addition, the CSP grant fostered the development of psychosocial rehabilitation principles and collaboration with the Massachusetts Rehabilitation Commission in the development of Independent Living Centers.

- The DMH HRD grant focused on identifying and removing barriers to hiring consumers in the Department.

Most Recently Approved Plan (September, 1991):

- Continue initiatives in CSP grant.

Revised or Additional 1992 Goals:

- New CSP Service System Improvement grant awarded in October ,1991 funded the development of a statewide coalition of consumer groups through outreach and organizing; the inclusion of cultural and linguistic minorities in the membership of the Alliance for the Mentally Ill; and additional training to further development of self-advocacy and community organizing for consumers.

Current Implementation/Accomplishments:

- A full-time outreach worker/organizer was hired by M*POWER to begin the task of building relationships with consumer organizations.

- AMI established an Advisory Committee of cultural and linguistic minority leaders to provide links to the African-American and Hispanic communities and hired two part-time organizers in July, 1992.

- A statewide needs assessment of the training needs of consumer organizations and clubhouses was completed by DMH; community organizers and consumers were hired to conduct trainings and provide on-going support. In response to consumers' expressed training needs, trainings were conducted in fundraising, media relations and community organizing in FY'92

- In terms of new program development, the second phase of the CCSS planning process (to commence in January, 1993) will include the use of a uniform needs assessment tool In addition, consumer preference focus groups addressing specific areas of the CCSS will result in reports to Area planning committees in the Spring of 1993. Finally, standards regarding minimum service systems as well as uniform definitions of these services will be applied to existing service systems in each Area.

- Multi-year Area plans, developed as a result of the CCSS planning process, will identify unmet needs and thereby facilitate more extensive exploration of new program models These will be integrated into a new, multi-year state plan by December, 1993 Information about new program types will be shared to assist Areas in creative thinking about ways to address consumer needs more effectively. In addition, the MI/CA task force (dually diagnosed), Massachusetts Rehabilitation Commission interagency workgroup, and supportive housing forums will fold into Area planning as their work is completed

C. Other Service Characteristics

Base Year:

- No statewide data on waiting lists for any service
- Tracking of inpatients awaiting placement began in August ,1988
- 631 LTSMI patients awaiting community placement
- 261 MR clients awaiting transfer to DMR
- 286 mentally ill/medically involved patients awaiting other placement
- Tracking case management waiting list began December ,1990: 563 adult clients

Most Recently Approved Plan (September, 1991):

- Advocate for additional case management staff.
- Place mentally retarded individuals in appropriate settings.
- Place MI/MI individuals in appropriate settings.

Revised or Additional 1992 Goals:

- As part of the restructuring of the mental health system, evaluate the current DMH case management system. Pending the outcome of this evaluation, make recommendations regarding case management model(s) and numbers of persons to be served. This, in conjunction with the CCSS planning process and Area needs assessments, should enable DMH to more carefully target its case management resources (October 1, 1993).

Current Implementation/Accomplishments:

- 1,203 adults on waiting list for case management (as of 9/30/92)
- 289 LTSMI inpatients awaiting community placement (as of 9/30/92)
- 23 mentally retarded inpatients awaiting placement with DMR (as of 9/30/92) - only a few of these clients are part of the original DMH/DMR initiative described under Requirement III Plan goals
- 73 MI/MI inpatients awaiting nursing home or other placement (as of 9/30/92)

Comparison with Base Year:

Inpatient and case management tracking now in place.

Reduced waiting list for placement of inpatients.

Increased waiting list for case management services.

Supporting Narrative:

Since August, 1988, DMH has tracked inpatients in three categories (LTSMI, MI/MI and MR/MI) who are awaiting placement to the community or other settings. Over the last four years, the number of patients in each of these categories has dropped dramatically through program development and work with other agencies.

DMH has also tracked the waiting list for case management services since December, 1990. This list has grown from 563 to 1,203 since that time. This reflects prior fiscal constraints on hiring additional case managers, and recent efforts to reduce inpatient utilization, shift toward community services, and create a system of managed care. More case managers and a current evaluation of case manager case loads and assignments should result in a decreased waiting list for case management services.

The lack of a statewide client information system has hindered DMH's ability to track the size of waiting lists for other community services. The planned registration and enrollment system (see Requirement II, C) will track waiting lists for all DMH services.

REQUIREMENT #V: The State plan shall describe the financial resources and staffing necessary to implement the requirements of such plan; including programs to train individuals as providers of mental health services, and the plan emphasizes training of providers of emergency health services regarding mental health.

A transition in service organization and redistribution of resources to reflect a more flexible system of comprehensive community based services is taking place at DMH. The changes are made possible as a result of the closure of three adult state hospitals, the consolidation of services in the remaining facilities concurrent with the privatization of acute care, and the implementation of CCSS planning. This reconfiguration enhances already established initiatives which have increased the type and amount of revenue generated by DMH since 1987. Taken together with the reality of static state budget appropriations for the foreseeable future, these opportunities should enable the Department to effectively target its resources to the development of additional community capacity. In addition to the structural and fiscal changes, DMH has also remained acutely aware of the need to attend to the system's human resources Programs were developed to ensure continuity of care to clients who were being transferred or moved to community settings during facility closings and to ensure maximum sensitivity and assistance to employees who would be affected personally as well. Finally, there is the need to train DMH and vendor staff on a variety of topics that enhance the care of DMH clients. DMH has chosen **Funds Available for Community Programs, Availability of Human Resources, Other Funding Sources,** and **Training** as the indicators to demonstrate implementation of this Requirement.

A. Funds Available for Community Programs

Base Year:

- 40.9% of adult funding expended on community programs.
- $0 in revenue generated by case management.
- $0 in revenue generated from rehab option (residential).

Most Recently Approved Plan (September, 1991):

- Ensure fiscal resources to :

  - Implement a system of public managed care.

- Complete the Comprehensive Community Support Systems;

- Shift resources from inpatient/institutional to outpatient/community based services

Revised or Additional 1992 Goals:

- Reallocate dollars from hospitals to community services account in FY'93 budget; increase community services account 25%.

Current Implementation/Accomplishments:

- 55.1% of adult funding expended on community programs.
- $8.6 million in revenue generated by case management.
- $15.6 million in revenue generated from Rehab Option.
- FY'93 community services account increased by more than 25%.

Comparison with Base Year:
DMH is reducing its use of state hospitals and increasing funding for community programs The FY'93 DMH budget reallocates more than $25 million from the state hospitals to the adult community services account. The adult community services account is increased by $44 million (includes reallocated hospital dollars, other targeted community service grants and reallocations, and a state appropriation in anticipation of federal Medicaid reimbursement for privatized acute care services). See chart in Appendix.

Supporting Narrative:

The total funding for adult community based services increased from $113.9 million in 1987 to $170 4 million in 1992. This growth occurred despite a budget reduction of $25 million between FY'90 and FY'92.

During this time, the proportion of service funding allocated to state hospitals dropped from 41% to 38% of the total services funding. The budget figures for FY'93 will show a sharp decrease in this percentage since the Department closed two state hospitals during FY'92 and most of a third which will be completely closed during FY'93.

Revenues generated by community services (case management and residential rehab option) went from nonexistent in FY'87 to over $24 million in FY'92 demonstrating the strong commitment of DMH to increasing the levels and availability of community based services DMH anticipates generating $17.2 million in rehab option and $9.7 million in case management revenue in FY'93

B. Availability of Human Resources

Base Year:

- Very low unemployment rate in Massachusetts
- High staff turnover rate in state-funded agencies (@90%)
- Human service jobs hard to fill
- Focus on recruitment, retention, utilization and training of workforce, and development of Human Resources management information systems

Most Recently Approved Plan (September, 1991):

- Ensure human resources to :

  - Implement a system of public managed care;

  - Complete the Comprehensive Community Support Systems;

  - Shift resources from inpatient/institutional to outpatient/community based services

- Focus training of caregivers on psychosocial rehabilitation. Include consumers in the workforce

- Ensure that recruitment, hiring and training policies improve the cultural/linguistic diversity of staff to meet the needs of a varied clientele.

- As resources are shifted from DMH institutions to general hospitals and other community-based services, assist qualified state employees to obtain employment in private sector programs

Revised or Additional 1992 Goals:

- Continue to pursue the goal of staff retention by expanding DMH's employee morale agenda
- Ensure that proper levels of staff are maintained in community programs through performance outcome monitoring of contracts (FY'92/'93).
- Ensure that review of RFP's, final contracts, and contract renewal proposals include staffing that meets the needs for all categories of persons served (ongoing).

- Computerize the records, files and documentation for contracting and affirmative action program functions (October 1, 1993).

- Continue and expand, if possible, DMH recruitment efforts with advocacy groups and community agencies, colleges and universities with significant minority/women representation

- Increase the representation of minority professionals.

- Expand the program, currently in operation in the Western Mass Area, to provide training, with tuition assistance, to qualified DMH employees, especially minorities, women, and disabled persons, to increase minority representation, particularly in the professional categories.

Current Implementation/Accomplishments:

- Restructuring of the mental health service delivery system and budget reductions have stimulated the development of various human resource related initiatives:

  - Provision of aggressive outplacement employment support including job placement, financial advice, pre-retirement planning and other relevant employee assistance areas.

  - Development and funding of re-training programs for staff where such programs are deemed necessary to ensure positive outplacement results.

  - Development, negotiation and implementation of employee bonus plans designed to ensure retention of staff during facility consolidation and privatization initiatives, complementing concurrent outplacement activities.

  - DMH advocacy for the Early Retirement Incentive Program, affording affected employees additional options upon the discontinuation of their positions.

  - Aggressive and ongoing negotiation with affected union principals to effect an agreed-upon mix of provider and state-operated services including the establishment of an Office of Competitive Bidding, enabling state employees to bid competitively for DMH contracts.

  - Coordination of the filling of vacancies on a statewide basis within DMH to ensure employees in closing facilities and privatized programs priority in the filling of these positions.

  - Encouraging providers to hire DMH staff confronted with interruption in their employment.

  - Aggressive administration of civil service certifications for all Case Management positions, ensuring the retention of incumbents and affording case-carrying employees tenure privileges, effectively insulating them from future seniority-driven layoff/bumping activity.

- Other implementation initiatives:

  - Convened a task force (FY'92) to review and determine standards for staffing on inpatient units to maintain safety, support ongoing active treatment, and meet minimum accreditation and certification standards.

- Development and implementation of performance outcome measures in purchase of service contracts (see specifics in Requirement #II).

- Monitoring workforce statistics to insure equitable distribution of protected group employees by EEO job category through the application of the Provider Workforce Utilization Analysis/Goal Setting Summary. Quarterly reviews are established for agencies found to have hiring deficiencies, i.e. less than goal parity for minorities, women, and the disabled, with special emphasis given to high level positions and board membership.

- Requiring prospective providers of acute and residential care to address the (staffing) needs of cultural and linguistic minority clients in their proposal(s) during the contract review process.

Comparison with Base Year:
Human resource development shifted markedly from 1987 to the present. Significant changes in the economy and a new administration focused DMH on downsizing its own workforce and privatizing previously state-provided services.

The development of human resources to increase access to services for special populations was markedly improved between the base year and the current one especially regarding consideration given to the needs of the disabled and the requirements of Section 504 of the Rehabilitation Act of 1973 and Title VI as it pertains to cultural and linguistic minorities.

Supporting Narrative:

Maintenance of appropriate staffing levels and the retention of specialized staff is a significant challenge to human service agencies even during periods of minimal systems change and plentiful budget allocations These challenges become even more acute during periods of funding level reductions and major shifts in service delivery models. While it can be said that the actual number of caregivers in the mental health service delivery system has not been reduced with the privatization of certain program activities, the shift from public to private services in many areas has resulted in some disruption within the public/state employee workforce. DMH has and will continue to implement specific strategies to address this unavoidable disruption, retain trained and specialized staff within the mental health service delivery system and support its employees during this period of change in their own personal employment situations.

In the process of restructuring the manner in which mental health services are delivered in Massachusetts, DMH placed significant emphasis on addressing the needs of employees impacted by these restructuring activities. These initiatives, detailed above under "Current Implementation," have translated into extremely positive and employee-supportive results in the following DMH-initiated closing/privatization activities:

Partnership Clinic Privatization

Of the 829 employees affected by the privatization of DMH Partnership clinics at the end of FY'91, 371 or 44.75% of these employees were rehired by the vendor to which they had been assigned 222 or 48.47% of these employees opted for reassignment to other positions within DMH.

74 employees who retired as a result of their positions being privatized through this initiative were able to have their retirement benefits recalculated and enhanced in accordance with the Early Retirement Incentive Program.

Metropolitan State Hospital Closure

Of the 735 employees at Metropolitan State Hospital at the initiation of the phasedown of this facility, only 48 individuals were without employment upon closure.

In addition to extensive outplacement activities, 365 Metropolitan State Hospital employees were afforded transfers within DMH to other agency worksites. Within this number of transfers were 153 employee transfers designated to occur with client transfers, allowing staff to remain with clients in their care and to further promote continuity of care during this process.

49 employees who retired as result of the closing of Metropolitan State Hospital were able to have their retirement benefits recalculated and enhanced in accordance with the Early Retirement Incentive Program.

Northampton State Hospital (Scheduled to Close May, 1993)

A major focus of the Northampton State Hospital human resources-based component of the facility consolidation initiative has involved staff re-training and aggressive outplacement. A sample of training programs offered through the facility and in collaboration with higher education centers in Western Massachusetts is highlighted below. The numbers referenced after the specific programs reflect the level of employee participation in each course.

Basic Reading Skills	**(13)**
GED Preparation	**(12)**
Nurses Aide Training	**(80)**
Welding	**(31)**
Power Plant Operator/2nd Class License	**(25)**
Commercial Driver's License Exam Preparation	**(37)**
Keyboarding	**(63)**
Learning DOS	**(54)**
WordPerfect	**(63)**
Advanced WordPerfect	**(18)**
Understanding and Using Personal Computers	**(63)**
Basic Lotus 1-2-3	**(67)**
Intermediate Lotus 1-2 -3	**(18)**
English Second Language	**(8)**
Starting Your Own Business	**(17)**
Career Renewal Workshop	**(15)**
Introduction to Business	**(10)**
EMT Basic Course	**(12)**
Business English	**(13)**

Similar to Metropolitan State Hospital, a specific bonus program was also negotiated and implemented for NSH employees designed to complement outplacement efforts and ensure continuity during the planned closure proceedings.

68 employees who retired as a result of the anticipated closing of NSH were able to have their retirement benefits recalculated and enhanced in accordance with the Early Retirement Incentive Program.

Danvers to Tewksbury Consolidation

The transfer of clinical operations from Danvers State Hospital to Tewksbury Public Health Hospital was accomplished with a minimum of disruption to the employment status of DMH employees. While on-site outplacement and career counseling services were available, an overwhelming majority of Danvers State Hospital staff used aggressively-negotiated transfer/reassignment privileges to continue their employment at DMH/Tewksbury, DPH/Tewksbury or DMR Hogan/Berry Campus.

Danvers employees not wishing to transfer to Tewksbury or the DMR Hogan/Berry Campus or whose limited seniority limited their options at these sites were afforded equivalent vacancies at other DMH worksites.

43 employees who retired as result of the closing of DSH were able to have their retirement benefits recalculated and enhanced in accordance with the Early Retirement Incentive Program

Bridgewater Treatment Center

A majority of the employee support/outplacement efforts involving the privatization of the Bridgewater Treatment Center focuses on the hiring of current BTC employees by the vendor, JRI.

As of September, 1992, 4 Treatment Center employees were offered positions with JRI, 2 accepted An additional 27 employees were actively involved in the interview process associated with the phasing - in of JRI operations

11 incumbents in DMH state positions will remain at the Treatment Center to oversee JRI operations It is projected that all other state employees at the Treatment Center not hired by JRI will be offered employment in equivalent DMH state positions at other agency worksites.

8 employees who retired as a result of the privatizing of Bridgewater Treatment Center were able to have their retirement benefits recalculated and enhanced in accordance with the Early Retirement Incentive Program.

The percentage of former DMH staff unemployed after all closings, privatization, consolidation is 8%.

C. Other Funding Sources

Base Year:

- DMH submitted an amendment to the Medicaid State Plan to allow billing for targeted case management services
- $0 revenue from case management services
- $0 revenue from Rehabilitation Option billing
- $3.9 million in hospital revenue
- $4.8 million CMHC revenue
- $0 revenue from Choice rents (DMH community housing program)

Most Recently Approved Plan (September, 1991):

- Increase revenues by billing Medicaid for targeted case management and Rehabilitation Option services.
- Work with the legislature to allow continued revenue retention by DMH.
- Develop legislation allowing DMH (contracted) providers to receive third party revenue, including Medicaid and Medicare, as an offset to state program costs rather than requiring DMH to generate non-tax revenues for the General Fund.
- Work with providers to implement the above revenue initiative.

Revised or Additional 1992 Goals:

- Continue revenue initiatives with the exception of pursuing the goal of retained revenue The legislature eliminated this practice for executive agencies.
- Reduce the number of inpatient beds at each of three CMHC's to 16, thereby rendering them eligible for Medicaid reimbursement.
- Close three state hospitals and privatize most acute and some continuing care for DMH priority clients by contracting with general and private hospitals for "replacement units" (FY'92-'93)

Current Implementation/Accomplishments:

- $8.6 million/year generated from case management services
- $15.6 million/year generated from Rehab Option services

- $5.4 million/year generated from hospital services
- $7.9 million/year generated from CMHC services
- $125,000/year generated from Choice rents

Comparison with Base Year:
Department generated revenue has increased 500% since 1987. This significant increase is due in large part to two initiatives aimed at reaping income from the provision of community-based services. In addition, in FY'90, DMH began billing Medicare for physician services delivered in state facilities, regardless of the certification status of the facility. In addition to gaining Medicaid reimbursement at three CMHC's, the most recent strategy is DMH's contractual arrangements to buy "replacement units" in general hospitals to replace acute (and some continuing) care previously provided in non-certified state hospitals, in a reimbursable setting. The combination of federal and private reimbursement sources is expected to lower the net costs to the state by a significant margin and enable DMH to redirect those dollars to community services. See Revenue Chart in Appendix.

D. Training

Base Year:

- Training was provided for case managers. No formal training was available on psychosocial rehabilitation. (Nine training institutes on psychosocial rehabilitation were held in 1989-90.)
- A statewide AIDS coordinator was appointed.
- A first "Train the Trainer" training program regarding AIDS was developed

Most Recently Approved Plan (September, 1991):

- Provide training for case managers on a variety of topics relevant to serving seriously mentally ill individuals and require all new case managers hired to complete the four day overview training Case manager training is discussed more fully in Requirement VII.
- Provide training for professional staff (inpatient and outpatient) on psychosocial rehabilitation theory and practice.
- Provide training for consumers to enable them to participate actively in DMH activities (See Requirement I).
- Provide training to DMH staff regarding implementation of various quality assurance mechanisms (see Requirement I).

- Provide training to Area planning committees regarding design of the Comprehensive Community Support Systems (see Requirement I).

- Provide AIDS training using "Train the Trainer" model for state employees; encourage vendors to attend as well.

- Continue training to implement appropriate infection control procedures in facilities.

Revised or Additional 1992 Goals:

- Hire a DMH Director of Training (FY'92).
- Catalog and coordinate all training efforts being offered by DMH state and vendor agencies (FY'92/'93).

- Develop a Core Curriculum emphasizing the role of the consumer and including a module on culturally competent service delivery (FY'93).

- Develop plan to teach the Core Curriculum to every DMH and vendor employee Priority groups are "replacement unit", residential and DMH inpatient facility staff (FY'93).

- Provide nine training sessions in advocacy for consumers and family members by October 1, 1993.

- Plan Human Resource Development training for senior DMH staff (including Area Directors) with Human Resource Associates of Western Massachusetts, a NIMH funded organization (FY'93)

- Produce additional teaching materials for use with SMI individuals regarding AIDS.

- Provide training for DMH managers on Total Quality Management (FY'93).

Current Implementation/Accomplishments:

- Extensive trainings for consumers were conducted during 1992.

- Training on psychosocial rehabilitation was incorporated into case manager training

- Training sessions were conducted for each of the nine Area planning committees to prepare for CCSS planning and system design during 1992.

- Quarterly training days around the basic components of the Core Curriculum are planned, and will be available to all state and vendor training directors. Included in the planning are the state's various professional societies, medical schools and academic departments of several universities The training, which will eventually be extended to all state and vendor employees by their respective Area Directors, includes basic standards of practice as well as emergency services issues.

- The Department of Higher Education and DMH are jointly constructing a certification program for Residential House staff and Mental Health Workers. This program is voluntary and will include basic standards of practice as well as dealing with emergency situations.

- A videotape was developed and filmed at Solomon Carter Fuller Mental Health Center in Boston (a DMH operated facility) with clients in the drop-in center. A written curriculum accompanies the videotape and provides a step by step approach to teaching risk reduction to the SMI It became available in June, 1992 and is the only one of its kind. It has been sold nationally and internationally.

- The AIDS training curriculum continues to be used for state and vendor employees It consists of four modules (101-104) that use a "train the trainer" approach to help the participants work through difficult affective issues and solidify behavioral and interpersonal learning by introducing techniques like role play, values clarification, group process, rehearsal and guided imagery

  AIDS 101 covers medical and central nervous system aspects, antibody testing, psychosocial impact and policy issues. AIDS 102 covers intravenous drug use and sexual risk reduction AIDS 103 includes the ethical and psychosocial impact of HIV and stereotyping and discrimination AIDS 104 is care for the caregiver and covers stress management and psychological coping in the context of AIDS.

- An infection control task force was convened in May, 1992 to evaluate implementation of the new OSHA recommendations.

Comparison with Base Year:
Training in all Areas increased significantly With the hiring of a DMH Training Director and the coordination of training efforts, it is anticipated that DMH resources will be used more effectively DMH is especially pleased with the development and implementation of a training program for consumers which has led to a dramatic increase in the numbers and level of participation by consumers in all DMH activities

REQUIREMENT #VI: The State plan shall provide for activities to reduce the rate of hospitalization of individuals with serious mental illnesses.

DMH has achieved a reduction in the rate of hospitalization of individuals with serious mental illness through improved monitoring and reporting mechanisms for screening, admission, utilization and discharge, continued development of community alternatives, and improved reporting systems that track clients waiting for community placement. The closure and consolidation of state hospitals will also enable DMH to free up resources formerly tied up in maintenance of underutilized hospital facilities to support housing and other necessary community rehabilitative and support services for clients who may have been hospitalized in the past due to the lack of appropriate and available alternatives. The statewide needs assessment being conducted as part of the DMH restructuring of its service delivery system will identify gaps and spur the development of program models for community-based services. Finally, the privatization of acute care and the collaboration with MHMA, Inc., the Medicaid mental health and substance abuse vendor, to develop additional community diversion services, should also have a significant effect on reducing the rate of hospitalization. DMH has chosen **Clients in State Hospitals** and **Programmatic Initiatives to Reduce Hospitalization Rates** as the indicators to demonstrate implementation of this Requirement.

A. Clients in State Hospitals

Base Year:

- 172 adult admissions per 100,000 population (n=10,324)
- 86% of patients discharged within 90 days
- 45.6 adult census per 100,000 population (n=2,743)
- 47% of census with length of stay > 1 year (n=1,299)
- 952 court-ordered inpatient admissions to DMH facilities (Note: court ordered admissions include all M.G.L. Section 15's and 16's.)

Most Recently Approved Plan (September, 1991):

- Place targeted number of DMH inpatient hospital beds on hold pending the final recommendations of the Governor's Special Commission. The Commission report recommended a reduction from 2,004 to 1,000 state hospital beds by the end of FY'92 after closing three state hospitals.

Revised or Additional 1992 Goals:

- Revise state operated bed capacity to1,475: includes 1,164 hospital and 311 CMHC beds (by October 1, 1993).
- Target number of acute replacement beds: 228 (October 1, 1993).
- Target number of intermediate/continuing care replacement beds: 75 (October 1, 1993).

Current Implementation/Accomplishments:

- 102 adult admissions per 100,000 population (n=6,163)
- 81% of patients discharged within 90 days
- 25.8 adult census per 100,000 population (n=1,553)
- 37% of census with length of stay > 1 year (n=575)
- 687 court-ordered admissions to DMH facilities.
- Current DMH state operated bed capacity is: 1,683; includes 1,302 hospital and 381 CMHC beds.

Comparison with Base Year:
Admissions per capita reduced 42%
Proportion of patients discharged within 90 days fell from 86% to 81%
Census per capita down 41%
Proportion of long-stay patients reduced from 47% to 37%
Number of court-ordered admissions reduced by 265 per year (28%)

Note: Figures include patients age 19 and above in state hospitals and inpatient units in state-operated community mental health centers. They do not include patients in general hospital replacement units operated under contract with DMH.

Supporting Narrative:

DMH has dramatically reduced inpatient utilization since 1987 - initially through reduced admissions and in the last few years through placements for the long-term population. The one negative change - decrease in number of patients discharged by day 90 - is a statistical artifact caused by better diversion of acute patients to general hospitals, resulting in more of the patients who are admitted being long-term. DMH presence in the court system of the Commonwealth has substantially reduced court-ordered inpatient admissions.

A report to the Commissioner from the Future of State Hospitals workgroup in December, 1992 will undoubtedly help to shape future decisions regarding the size and scope of the remaining state hospital system.

B. Programmatic Initiatives to Reduce Hospitalization Rates

Base Year:

- Emergency services complete (24 hour/7 days) in 13 of 40 Areas
- No diversion beds developed.
- Inpatient bed capacity: 2,331 (from 1987 Capital Plan)
- Inpatient average daily census: 2,399
- Number of admissions: 10,324
- No formal arrangement in 1987 between DMH and DPH regarding Determination of Need (DoN) collaboration to approve hospital requests for psychiatric beds. On 6/20/89 DPH adopted DoN Guidelines for Conversion of Acute Care Beds to Inpatient Psychiatric Beds. Guidelines required applicants to demonstrate commitment to serve DMH priority clients and to a working agreement with DMH as a condition of approval.

Most Recently Approved Plan (September, 1991):

- Complete emergency services in all 9 Areas (1990 reorganization reduced the number of Areas from 40 to 9).
- Reduce inpatient average daily census.
- Develop respite (diversion) beds in all 9 Areas.
- Reduce number of admissions.
- Support legislation amending the insurance law to cover previously non-covered mental health services.
- Reduce inpatient hospital bed capacity.

Revised or Additional 1992 Goals:

- Develop additional diversionary services (by October 1, 1993).
- Privatize acute inpatient care in selected Areas (by October 1, 1993).
- Continue to support changes in insurance law.
- Operationalize Utilization Management principles to ensure appropriate utilization of clinical programs (October 1, 1993).

Current Implementation/Accomplishments:

- Emergency services complete in all 9 Areas (27 programs)
- Have achieved privatization of acute inpatient care in 2 of 9 Areas, others underway

- Respite (diversion) beds available in all Areas.
- Presently coordinating efforts with Medicaid's mental health and substance abuse managed care vendor, MHMA, to expand diversionary services beginning in December, 1992.
- Reduced state hospital inpatient bed capacity to 1,302 to date.
- Inpatient average daily census: 1,325 (9/30/92, includes state hospitals and CMHC's).
- Recently enacted health care legislation includes a provision directing the Division of Insurance to allow substitution of community alternative (i.e. diversion, day treatment, etc.) services for the inpatient psychiatric benefit for clients who are privately insured. DMH presented testimony to the Division regarding implementation of this provision.
- Number of admissions: 6,163 (FY'92).

Comparison with Base Year:
Significant reduction in inpatient bed utilization and capacity.

Significant expansion in emergency and diversionary services in all Areas. Plans call for further expansion of diversionary services and expansion of acute inpatient care privatization.

Supporting Narrative:

The Department made significant progress in its efforts to reduce hospitalization rates. The 40% reduction in the number of admissions from 10,324 in 1987 to 6,163 in 1992 is dramatic. This accomplishment was achieved through the expansion of the emergency/diversion system and the improved use of monitoring and reporting mechanisms for admission and discharge, including an inpatient database that generates monthly reports showing inpatient utilization by facility and catchment area and a database of patients awaiting community placement. All admissions are now screened and diverted to alternative settings, wherever possible.

As the acute care privatization initiative proceeds, this gatekeeping function will remain in place in order to assure appropriate admission to the privatized units as well.

There are plans to further expand the diversionary system this fiscal year. In collaboration with MHMA, the state's Medicaid managed care vendor, this system will be expanded to meet the needs of the Medicaid managed care initiative as well. Both MHMA and DMH are seeking to achieve further reductions in inpatient utilization through redirecting inpatient dollars to the development of community based services including diversion and support services.

MHMA and DMH are also planning to use the same emergency screening teams in order to screen and divert admissions and to create a seamless system Joint standards will be developed for the screening teams In addition, DMH and MHMA will be developing better systems of managing the care provided to their mutual consumer population Not only will there be collaboration around the purchase of emergency/diversion services but both entities will be seeking to reduce length of stay through the provision of short term case management to facilitate discharge from inpatient care and linkage to community based care

The Department's CCSS reorganization will also contribute to the reduction in hospitalization rates. As this reorganization is implemented, it will be possible to provide better supports to consumers in the community in accordance with their needs and preferences. Augmenting the community support system is directly correlated to the reductions in the use of inpatient care both in terms of admission rates as well as length of stay for those who are admitted. As previously mentioned, dollars saved from the closing and privatization of inpatient hospital services will be invested in community support programs

REQUIREMENT #VII :

(A) The State plan shall require the provision of case management services to each individual with a serious mental illness in the State who receives substantial amounts of public funds or services.

(B) The State plan provides that the requirement of sub-paragraph (A) will not be substantially completed until the end of fiscal year 1993.

As DMH has moved to privatize acute inpatient care, restructure its service delivery system and implement public managed care within comprehensive community support systems, the focus on models of case management, locus of service provision and target population for these services has intensified. There is an active and ongoing examination of the case management model developed in 1987, primarily an "enhanced brokerage" model, and interest in modifying the model to also include intensive clinical case management and the use of consumer case managers to augment the current state-operated system. DMH has substantially increased the number of case managers and the number of clients receiving case management services since the beginning of planning under P.L.99-660 but must ensure that the model supports the changing service system. Providing ongoing training for case managers is also a priority. DMH has chosen **Population Receiving Case Management Services, Case Management Training** and **Case Management Model** as the indicators to demonstrate implementation of this Requirement.

A. Size of Population Receiving Case Management Services

Base Year:

- 3,565 clients received case management services
- Caseload represents 8% of estimated need of entire SMI population (44,206)
- Caseload represents 16% of estimated need of DMH planning population (22,106)

Most Recently Approved Plan (September, 1991):

- Provide case management services for 22,106 clients
- Advocate for 106 additional case managers

Revised or Additional 1992 Goals:

NOTE: In its September,1991 State plan, DMH targeted 22,106 adult clients for case management services. This projection was unrealistic based upon known appropriation levels and identified, eligible clients. Numbers were derived from prevalence estimates of overall need statewide and mistakenly incorporated as target numbers for development.

- Revise target for case managed clients to: 7,200 by October 1, 1993.

Current Implementation/Accomplishments:

- 7,111 adults receiving case management as of 9/30/92. There are 413 case managers.
- Caseload represents 98.7% of need using revised target (7,200)
- Caseload represents 16.1% of entire SMI population (44,206)
- Caseload represents 32.2% of entire DMH planning population (22,106)

Comparison with Base Year:
More clients are receiving case management services (almost 100% increase) and the Department is currently able to fill case manager vacancies. 35 new case managers were hired in FY'92.

Supporting Narrative:

Eligibility for case management services is governed by DMH Policy #87-3 (see Appendix). Currently, services are provided to adults who meet DMH priority client eligibility criteria , as defined by DMH Policy #89-3, (see Appendix) and/or those adults who, as a result of serious mental illness are unable to meet life support needs for food, shelter, clothing and health care. Priority for case management services is given to eligible clients who are awaiting discharge from DMH inpatient units (and acute replacement units in general hospitals) and seriously mentally ill clients who are homeless. Case management services are provided to other DMH priority clients based on clinical appropriateness and resource availability.

As noted above, case management targets were revised to reflect a more realistic appraisal of client eligibility and available resources. It is also important to note that the number of priority clients receiving case management services is a dynamic number with clients often moving in and out of the system.

B. Case Management Training

Base Year:

- Training was provided to all case managers regarding the philosophy and principles of the new case management policy. Additional training was provided regarding ISP regulations and ISP preparation. A comprehensive curriculum and training guide for case managers was prepared in 1989.

Most Recently Approved Plan (September, 1991):

- Provide training for case managers on a variety of topics relevant to serving seriously mentally ill individuals and require all new case managers hired to complete the four day overview training

Current Implementation/Accomplishments:

- Case Management training in DMH is decentralized by Areas to be fully responsive to the needs of consumers in their communities. Trainings, therefore, are guided by Central Office general directive and Area specific need.

- In 1992, statewide training was provided for case managers on the following topics: facilitating the needs of the deaf and hard of hearing consumer; the role of psychosocial rehabilitation in recovery; enhancing basic case management skills (ISP, human rights, etc.); and integrating the consumer's housing needs in the community as part of the comprehensive treatment plan.

- In addition to statewide trainings, Area level on-going supervision for case managers is provided and various Areas emphasize further specific need. In 1992 for example, training regarding the dually-diagnosed consumer took place in 5 Areas, and ISP planning in 3 Areas.

- As the DMH Core Curriculum is developed in the coming year, case managers will be able to participate in statewide training related to the Core Curriculum topics. Case manager trainings are also being planned to facilitate the shift in delivery of health care from state-supported programs to privatized initiatives.

Comparison with Base Year:
Case management training is more topic specific and is focused on Area identified consumer needs. There is an increased focus on psychosocial rehabilitation.

C. Case Management Model

Base Year:

- The DMH case management policy (#87-3), developed in 1987, provides for an "enhanced brokerage" model of case management

Most Recently Approved Plan (September, 1991):

- Establish a workgroup to study other models of case management.

Revised or Additional 1992 Goals:

- Incorporate planning for case management in CCSS planning process.

Current Implementation/Accomplishments:

- A workgroup was established in January, 1992. Preliminary report sent to Commissioner in May, 1992 recommended actions for Area case management development, program evaluation and data collection.

Comparison with Base Year:
DMH is re-assessing the case management system it developed in 1987 and will recommend changes, as necessary, to the Commissioner. These will be implemented as CCSS planning proceeds.

Supporting Narrative:

In January, 1992, a workgroup comprised of DMH staff was established to look at the current "enhanced brokerage" case management model and compare it to a "level of care" case management model. Membership was soon expanded to include consumers and family members. It became clear that the current system is augmented by a variety of activities that are considered to be case management in each of the Areas. It also became clear that evaluation of the current system would require additional time as well as input from Area Directors.

In July 1992, a decision was made to incorporate case management planning into the ongoing CCSS participatory planning process. This process involves a description of models, data collection and identification of recommended new directions for program planning as an ongoing process to improve services to seriously mentally ill adults (and seriously mentally ill and severely emotionally disturbed children). By incorporating case management planning into the CCSS process, DMH will develop a clear picture of functions as well as programs and determine how these do or do not meet the needs of DMH consumers.

Area plans due in Summer, 1993 will include recommendations regarding case management. Areas will need to address short term capacity, specifically the needs for timely service linkage for DMH priority clients being discharged from hospitals, including all acute replacement units currently on line and Medicaid reimbursable beds in other private and general hospitals. DMH expects to maintain case management as a state-operated program to ensure accountability.

It is expected that activities related to the homeless mentally ill will require a response vis a vis case management planning prior to Summer,1993. The Department is working on securing additional case management resources, including consumer case managers, to improve DMH's capacity to respond to the needs of mentally ill homeless persons. To date, the Department has committed to establishing three Continuous Treatment Teams as an adjunct to case management in FY'94 and is pursuing replication of the case management aide model now in place in Colorado and Texas. Case management aides would be providing monitoring for recently housed, formerly homeless consumers and those at risk of homelessness. Monitoring will include adequacy of food and food preparation, budgeting, planning a schedule of daily activities and medication compliance. The Department of Public Health has agreed to pay for a substance abuse counselor for each team.

REQUIREMENT #VIII: The State plan shall provide for the establishment and implementation of a program of outreach to, and services for, individuals with serious mental illnesses who are homeless.

During the past year a consultant was hired through a technical assistance grant to work with DMH as part of ongoing planning and implementation for the Governor's Special Commission on Consolidation of Health and Human Services Institutional Facilities to produce an estimate of the number of seriously mentally ill homeless persons and to make recommendations regarding housing, services and outreach. A particular focus of this work was its emphasis on establishing meaningful interagency communication, including direction and support from the Executive Office of Health and Human Services, to implement successful strategies for dealing with this target population. This particularly vulnerable group continues to present significant challenges to DMH and other state agencies charged with the responsibility for coordinating programs and services to ameliorate their problems. These challenges were manifested in the Department's efforts to close and consolidate several state hospitals while ensuring that no patient was discharged from any DMH operated or funded program to a homeless shelter. In addition, the effects of a persistently high rate of unemployment, a stubborn recession and decreased housing resources in Massachusetts are difficult to calculate. Implementing the recommendations received as a result of the technical assistance grant will be the challenge for DMH in 1993 and beyond. DMH has chosen **Population Served, Homeless Programs,** and **Planning** as the indicators to demonstrate progress toward implementation of this Requirement.

A. Population Served

Base Year:

- No specific count of the number of homeless mentally ill served.

Most Recently Approved Plan (September, 1991):

- Plan for the homeless mentally ill through the Statewide Workgroup on Facility Consolidation (FY'92/'93). Create a separate task force on the SMI homeless.

Current Implementation/Accomplishments:

- The Human Services Resource Institute (HSRI) was engaged to prepare the Task Force Report on Homelessness and Mental Illness for the Governor's Special Commission. As a result of this report, DMH now has estimates of the target population and numerous recommendations for

addressing the needs of this population which are being factored into the CCSS planning process and addressed at the interagency level. Based on the research of Lehman and Cordray (1991 unpublished paper titled: "Prevalence of Alcohol, Drug and Mental Disorders Among the Homeless: One More Time") it is estimated that of 7,198 to 8,957 homeless adults statewide, there are between 1,512 and 1,881 SMI single adults in shelters in Massachusetts with severe DSM-III Axis I disorders,of whom 957 to 1,115 have co-occurring substance abuse diagnoses. These groups constitute the minimum target population for DMH planning purposes. Although DMH does not limit client eligibility to diagnoses of Axis I disorders, there is no recognized method for estimating the prevalence of homeless mentally ill individuals with Axis II disorders who may also meet other DMH criteria related to functional level and duration of illness. This will be a subject for future analysis.

Comparison with Base Year:
DMH now has an estimate of the number of SMI homeless adults in Massachusetts which will aid greatly in its efforts to plan services for this population.

B. Homeless Programs

Base Year:

- Limited outreach services to the homeless mentally ill. No specific priority assigned to the homeless for service provision.

- Only 65 beds were specifically earmarked for the homeless mentally ill. The majority of these were located in Metro Boston.

Most Recently Approved Plan (September, 1991):

- Establish statewide initiatives to plan for and address the needs of the homeless mentally ill
- Add 72 new beds in Metro Boston for the homeless mentally ill.

Current Implementation/Accomplishments:

- DMH achieved the target in the most recently approved plan and developed additional services. There are presently more than 360 beds on line which are exclusively earmarked to serve the homeless mentally ill. In addition, there was an expansion of the services available for this population through the use of various state and federal resources.

- There are 3 transitional shelters serving 117 homeless mentally ill persons in Metro Boston.

- 120 new housing units for the homeless mentally ill (HUD/NIMH) were added in 1992; 978 homeless mentally ill persons were served through the PATH grant outreach program (in 68 shelters statewide).

Comparison with Base Year:
Significant progress was made in the level of service delivery to this population as well as the prioritization of their service needs.

Supporting Narrative:

DMH has made significant strides in developing programs for the homeless mentally ill. The HSRI Task Force Report estimates that of the approxi mately 1,500-1,800 SMI homeless persons in Massachusetts, between 995-1,243, are located in Metro Boston. Therefore, it is this Area where the majority of the Department's efforts are concentrated.

There are presently three transitional shelters in Metro Boston serving 117 homeless persons. These shelters assist the homeless mentally ill population to transition to more permanent housing options. The Department's NIMH grant provided 120 new units of housing in Metro Boston for the homeless mentally ill during FY'92. A primary referral source for this housing is the Department's transitional shelter network.

The state's Programs for Assistance in Transition from Homelessness (PATH) formula grant is exclusively outreach oriented. 17.6 FTE social workers are deployed across the state in 68 shelters. Their goal is to identify homeless mentally ill persons in those shelters and link them to appropriate services. In nine months, 978 homeless persons were served through this program with a total of 4,708 direct care contacts. The program made 1,390 referrals to various support services for the identified population. Case management, mental health treatment, substance abuse programs, medical services and emergency services constituted the majority of these referrals. In addition, 240 referrals were made to various supported independent housing alternatives. 37%, or 88, of those referrals resulted in successful placements.

The PATH formula grant also provides training for shelter staff to augment their skills and capabilities in addressing the needs of the homeless mentally ill. Approximately 57 trainings were provided from October, 1991 through June, 1992.

In Metro Boston, there is a Homeless Outreach Team which receives referrals from various sources. This team is deployed wherever necessary to assist homeless persons in gaining access to necessary services. The Department also funds nurses who work in non-DMH Boston shelters, and an intensive care detoxification program for substance abusing homeless mentally ill persons.

The homeless population is a priority for receipt of DMH case management services, however, with the current data base, it is not possible to determine exactly how many of the state's case managed population are homeless. The Department is working on securing additional case management resources, including consumer case managers, to improve DMH's capacity to respond to the needs of mentally ill homeless persons. To date, the Department has committed to establishing three Continuous Treatment Teams as an adjunct to case management in FY'94 and is pursuing replication of the case management aide model now in place in Colorado and Texas. Case management aides would be providing monitoring for recently housed, formerly homeless consumers and those at risk of homelessness. Monitoring will include adequacy of food and food preparation, budgeting, planning a schedule of daily activities and medication compliance. The Department of Public Health has agreed to pay for a substance abuse counselor for each team.

In FY'93 DMH expects to receive funding to extend the number of residential beds for the target population. When the final state budget was signed in July, 1992, $2 million was included for this purpose. With these funds, DMH expects to create 100 new beds in the Metro Boston Area.

The Department's plans also call for the privatization and reorganization of the Metro Boston Area over the next two years. This planning will result in the total reorganization of the Department's service system in this Area and the development of one or more comprehensive community support systems of care there. Through this reorganization, funds presently earmarked for inpatient care may be redirected to the provision of community services. A major priority for new service development is in the area of expanded services to the homeless mentally ill.

C. Planning

Base Year:

- Planning for HMI was Area based and limited.

Most Recently Approved Plan (September, 1991):

- Identify HMI in need of services. Establish a sub-group of the Statewide Work Group on Facility Consolidation to assess needs of HMI adults, children and adolescents and recommend pilot programs to address those needs.

Current Implementation/Accomplishments:

- Three inter-related planning activities are in place.

  - A HMI Committee under the statewide Work Group on Facility Consolidation has met monthly since October, 1991. The Committee includes approximately 60 consumers, family members, clinicians, advocates, DMH and other state agency staff and academics.

  - A technical assistance consultation and Action Plan was completed in December, 1992. Work products included: an estimate of the size of the homeless mentally ill population based on the DMH priority client population; information on the size and characteristics of sub-populations including those with multiple disabilities and linguistic/cultural minorities; identification of successful models from across the nation that focus on housing, services, system and interagency coordination; and an analysis of resource utilization and availability and ways to maximize resources. The consultants will assist DMH in applying for a federal ACCESS grant for interagency collaboration.

  - An Interagency Task Force on the HMI mandated by the Governor's Special Commission and co-chaired by the Secretary of Health and Human Services and the Secretary of Communities and Development.

- The Governor's Special Commission recommended that the HMI receive equal priority with those clients affected by facility consolidation. The equal priority process must include

- Intensive interagency collaboration and development of a comprehensive action plan by the Task Force which will incorporate the findings of the technical assistance consultation project.

- Pooling of agency expertise and resources to address the needs of the homeless mentally ill in a comprehensive fashion.

- Redeployment of resources as a result of DMH facility consolidation to address the unmet needs in the community, especially those of homeless mentally ill citizens.

- Support of pending legislation to authorize the development of community residential programs by the reappropriation of capital funds for an improved healthcare system and, in compliance with equal priority, to allow the use of these capital funds to support the development of housing for homeless mentally ill citizens.

- In August, DMH received the results of a technical assistance consultation on estimating the number of the HMI in Massachusetts. This report provides a point in time estimate, broken out by DMH Areas, of single adults living in shelters, on the streets, or in locations not typically considered residences, who meet the criteria of the DMH priority client policy (#89-3). This report was released in December, 1992 simultaneously with the four additional reports.

- The lawsuits referenced in the 1991 Progress Report charging DMH with failure to serve the HMI were combined into a single suit. A summary judgment ruled to dismiss the due process claims but the discrimination claims will go forward. The suit is currently in the state Appeals court.

Comparison with Base Year:
Increased focus on the HMI; development of methods of counting and serving this hard to serve population.

REQUIREMENT #X: The State plan shall describe the manner in which mental health services will be provided to individuals with serious mental illnesses residing in rural areas.

Defining services specifically for rural populations is a new focus for DMH. It is more appropriate to say that DMH is restructuring its entire service delivery system to ensure that priority clients in all parts of the state have access to services they need to live in communities of their choice, in the least restrictive setting. As a small, industrial state Massachusetts does not typically use traditional definitions of rurality. However, it does acknowledge that individuals who reside in areas of the state that are farthest from urban centers face particular challenges in gaining access to mental health services and overcoming isolation. Therefore, DMH has chosen **Access to Services** as the indicator to demonstrate implementation of this Requirement

A. Access to Services

Base Year:

No services were specifically targeted to individuals residing in rural areas of the state However, at that time there were 40 distinct service (catchment) areas within the Department providing local mental health services. The Department was subsequently re-organized administratively in 1990 into nine service delivery areas. Case management site offices were retained in many of the original catchment areas

Most Recently Approved Plan (September, 1991):

- Provide comprehensive community-based mental health services to priority population
- Provide case management services to priority clients; substantially implement target by 9/30/91

Revised or Additional 1992 Goals:

- Initiate local, area-based planning statewide; determine needs and service gaps based on local needs assessment (by October 1, 1993).
- Develop organizational models to provide Area offices with the ability to blend various public and private funding streams to maximize service delivery; each CCSS (natural service area) will also have designated functions that will assure attentiveness to the unique needs of that geographic area (Spring, 1993).
- Close two state hospitals and redirect funds from state inpatient facilities to expand community services (by June 30, 1992).

- Replace all acute and some continuing care in state hospitals with local replacement units in community/general hospitals (FY'92-'94).

- Close third state hospital (Northampton) in most rural area of the state - western Massachusetts - in May, 1993 and replace with acute and continuing care beds in community hospitals by July 1, 1993.

- Work cooperatively with Mental Health Management of America, Inc., Medicaid's mental health and substance abuse vendor, to develop mobile outreach, community diversion and other non-inpatient community mental health services (by October 1, 1993).

Current Implementation/Accomplishments:

- Emergency services are in place in each Area. Efforts are underway to increase mobile outreach capacity.

- The Comprehensive Community Support System (CCSS) planning process was initiated in the Fall of 1992 and will continue until Spring/Summer ,1993 at which time each Area will submit a multi-year Area plan to the Commissioner and Mental Health Planning Council.

- 543 new housing units were brought on line with FY'92 budget resources to support the consolidation and closure of the state hospitals; over $25 million in savings from the closures a... consolidation was redirected to community programs in the FY'93 budget.

Comparison with Base Year:
Massachusetts is a small industrial state and the technical definitions of rurality, based on population and proximity to urban areas, are not readily applicable. However, the Department recognizes that priority clients in certain areas of the state experience more difficulty in gaining access to services than others, and are more isolated. To address issues of both access and appropriateness of care, DMH dramatically increased both the number and diversity of community programs. The emphasis in the Area-based planning initiative is on locally determined services and increased outreach and access, essential for priority clients who live in the more isolated areas of the state.

REQUIREMENT #XI: The State plan shall contain an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children.

In 1990, a DMH task force on Incidence and Prevalence considered alternative procedures for measuring mental health needs in DMH Areas. The task force reviewed research findings and made recommendations for the final estimation procedures. This work resulted in the adoption of prevalence estimates the Department has used since then for its planning purposes and which are detailed in the state Plan It is anticipated that new directives regarding methods of determining prevalence forthcoming from NIMH in 1993 may result in a revision of these estimates

PART B: IMPLEMENTATION REPORT TOPICS

CHILD/ADOLESCENT PROGRESS REPORT

REQUIREMENT #I: The State plan shall provide for the establishment and implementation of an organized community-based system of care for children with serious emotional and mental disorders.

An organized, comprehensive community-based system of care must be guided by a consistent, continuous and cohesive participatory planning process and anchored by standards and regulations that ensure quality of care, appropriate oversight and a mechanism for continuous assessment and improvement. Furthermore, parents or guardians of severely emotionally disturbed youth, and to the extent practicable older adolescents themselves, must be included actively in the planning and standard-setting processes. Efforts must also be made to include members of cultural and linguistic minority groups who have historically experienced difficulty gaining access to mental health services. Therefore, the Department has chosen **Regulations and Standards, Planning,** and **Administration** as the indicators to demonstrate implementation of this Requirement.

A. Regulations and Standards

Base Year :

- There was no statewide Quality Assurance (QA) mechanism.
- There were no measures of performance outcome.
- Inpatient care was provided primarily in non-certified and non-accredited facilities. Adolescents were placed with adults in state hospital units or inpatient units of state operated community mental health centers.
- An implementation plan was developed in response to Executive Order 244 of 1984 which required the removal of all adolescents from state-operated adult inpatient units, and creation of a continuum of care for severely emotionally disturbed children.
- Inpatient care for children under 16 was provided at the Gaebler Children's Center, an uncertified state operated facility. Average daily census was 76, 20% above designated capacity.
- No residential programs were certified by HCFA.

Most Recently Approved Plan (September, 1991) :

- Explore the feasibility of HCFA certification for the Gaebler Children's Center.
- Develop standards defining the integration of a Comprehensive Community Support System (CCSS) by April, 1992.
- Incorporate performance indicators into all Purchase of Service contracts by June 30, 1993.

Revised or Additional 1992 Goals:

- Maintain certification or accreditation of state funded inpatient units serving adolescents.
- Develop and implement a quality management (QM) infrastructure to support ongoing and systematic assessment and improvement activities through-out all levels of the organization from Central Office to the Area Offices to the provider level (Provider self-monitoring).
- Revise target date to develop and implement incorporation of performance indicators into all purchase of service contracts as they come up on bid cycle (6/30/96).

Current Implementation/Accomplishments:

- The Governor approved the report of the Special Commission on Consolidation of Health and Institutional Facilities which recommended the closing of the Gaebler Children's Center and which rendered moot the issue of HCFA certification.
- Quality Management standards for the CCSS were developed and published in the CCSS guidance manual, Massachusetts Department of Mental Health, Developing Comprehensive Community Support Systems: A Guidance Manual for Area Participatory Planning, March, 1992.
- The Licensing and QM systems were streamlined (i.e. the licensing instrument was revised), so that neither entity duplicates areas of responsibility allocated to the other entity. A performance outcomes task force identified outcome measures to be applied across program codes and selected instruments to be used in evaluating performance. Pilot testing began in theFall of 1992. Participation in DMH outcome evaluation will be included as a requirement in all purchase of service contracts as they come up for bid on the 5-year bid cycle.
- State funded units serving adolescents have maintained their certification and accreditation status.
- An Office of Quality Management was established. In September 1992, the OQM began a training series on Provider self-monitoring.

Comparison with Base Year:
In FY'87 DMH had a fragmented QA system. It was retrospective in nature, and failed to assure the ongoing efficiency and effectiveness of programs. Significant progress has been made

Performance outcome measures have been identified by the state. Instruments to measure outcome are currently being tested on a stratified sample of providers. Scales will measure the impact of treatment on school adjustment, and interaction with family and peers, as well as consumer and family satisfaction with services.

DMH funds 45 inpatient beds for adolescents which are located in age appropnate, HCFA certified units

The Gaebler Children's Center closed in September, 1992 is being replaced by a continuum of services including inpatient, residential, and home and community based treatment. All inpatient and residential care to children will be provided in HCFA certified facilities.

All residential programs for children and adolescents meet HCFA certification standards and are certified providers under the Medicaid Rehabilitation Option.

Supporting Narrative:

The Provider self-monitonng series will instruct QM staff how to help their providers organize and implement a self-monitoring program. Once implemented, Provider self-monitoring will play a significant role in the Quality Management system, as it will ensure that providers develop and implement proactive systems to monitor the quality and effectiveness of the services they provide.

B. Planning

Base Year:

- DMH was re-organized after a legislatively designed split with Department of Mental Retardation in 1986, and its mission and planning were refocused on seriously mentally ill or severely emotionally disturbed children and adolescents (hereafter referred to as SED youth).

- The Department was in the first year of a three year plan developed in response to Executive Order 244 mandating the removal of all adolescents from the adult units of state hospitals

- In the Department, the Gaebler Children's Center was managed as a state hospital and was not under the control of the Division of Child-Adolescent Services.

Most Recently Approved Plan (September, 1991):

- Involve parents of SED youth in service planning.
- Establish participatory process to: refocus planning on development of public managed care; expand/restructure the community service system through the development of the CCSS design; pilot three to five Local Mental Health Authorities (LMHA) by the end of FY '92; involve parents of seriously mentally ill or severely emotionally disturbed youth and/or seriously mentally ill or severely emotionally disturbed youth themselves on the Consumer Advisory Council to the Office of Consumer and Ex-patient Relations.
- Develop interagency agreements with other child-serving agencies regarding service provision at the local level.
- Develop an interagency protocol in the Metro Boston Area to assure that out-of-home placements are prevented wherever possible.

Revised or Additional 1992 Goals:

- Revise the goal for Local Mental Health Authorities: relook at the role and functions of the nine DMH Area offices. Devise a plan to maintain the offices as DMH administrative entities that incorporate the LMHA principles of blended funding and protecting the service system from political shifts (Spring, 1993).
- Plan a continuum of care focused on community based services for children under age 14 to serve the profile of children previously hospitalized at the Gaebler Children's Center
- Establish Office of Policy and Planning.

Current Implementation/Accomplishments:

- Parents of SED youth are now represented on the Professional Advisory Committee to the Division of Child-Adolescent Services, and on the Commissioner's Statewide Advisory Council The Advisory Council to the Office of Consumer and Ex-patient Relations designated and filled two seats for adolescents, and one for a parent of a child under 12, with an alternate for each position. Parents and adolescents will have designated seats on Area Boards which are currently being reorganized
- An Office of Policy and Planning was established in February ,1992 A Policy and Planning Committee which includes senior staff from all DMH field and Central Office Divisions including the Child/Adolescent Division, meets weekly.

- Statewide workgroups comprised of all stakeholders in the mental health system recommended standards for policy implementation that resulted in a "Guidance Manual for Area Participatory Planning." The Managed Care workgroup addressed Services and Supports, Administrative Issues, Quality Management, and Consumer and Family Participation.

- Several groups emerged from the Participatory Planning Process:

  . A Mental Health Advocates Group: leading consumer and family advocates and directors of advocacy and professional organizations meet monthly with the Commissioner.

  . Multi-Cultural Advisory Committee with 125 members makes recommendations to the Commissioner regarding issues pertinent to the multi-cultural community as they relate to CCSS planning and implementation.

  . Academic Affiliates: assesses potential collaborations with DMH in education, training, evaluation, and research.

  . A Consumer and Ex-patient Advisory Council with 19 members and 19 alternates.

  . A Business Council: assists in the development of best practices for DMH non-profit providers and expanding areas for public/private partnership and philanthropic fundraising.

  . A Task Force on Services to Sexual Minorities: identifies needs and service models for consumers who have alternative sexual orientations.

- Training of (9) local, Area based planning committees occurred in March, 1992

- Area planning committees identified natural service areas, the basis for development of CCSS's These were approved by the Commissioner in August, 1992.

- A task force on Local Mental Health Authorities has been meeting to develop models A RFP to provide planning and technical assistance for the establishment of a Metro Boston public LMHA was issued in October, 1992.

- Two statewide meetings were held to explore minority concerns As a result, the previously existing children's Minority Subcommittee decided to become incorporated into the Multi-Cultural Advisory Committee Seven teams reflecting cultural, linguistic and geographic areas initiated planning activities which correspond to the CCSS but are specific to consumers of color

- Many state and private child-serving agencies and parents are participating in local level CCSS planning. Their task is to identify needed services and develop a comprehensive system. Creating a simplified consumer sensitive system for multi-agency service delivery is a key requirement.

- A Report to the Legislature on Interagency Services for Children and Adolescents in Metro Boston was submitted in April, 1992. Building on that report, DMH was awarded a planning grant of $150,000 from the Anna Casey Foundation under its Urban Mental Health Initiative. DMH is leading an interagency effort in a designated Boston neighborhood to explore the means by which public state and local funds and private funds can be blended in an early intervention effort directed at children at risk of mental illness.

Comparison with Base Year:
Planning in 1987 focused on the removal of adolescents from adult units of state inpatient facilities. Through activities of the past five years, DMH brought on line the services necessary to treat that population in settings which are appropriate in terms of age and degree of restrictiveness. DMH also was able to redirect resources from inpatient care to community treatment, despite budget cuts.

Comprehensive planning for children under age 14 was initiated in 1991. The recommendation to close the Gaebler Children's Center was based on the report of a broad based planning subcommittee which examined services for younger children. DMH has developed an implementation plan for serving children fitting the Gaebler profile within the community, and issued requests for proposals in October and November for intermediate and long-term hospital care and intensive residential treatment programs. Beds for less restrictive community-based programs will be solicited in Spring, 1993.

In 1987, advocates, legislators, and service providers were involved in the planning process, but minorities were poorly represented and neither parents of SED youth nor youth themselves were involved. The increase in participation by parents and adolescents has been dramatic, as has been the effort to involve and serve linguistic and racial minorities.

Planning is now integrated into all DMH activities at the Central Office and Area levels. This has significantly increased the attention given to children's services and the integration of children's services within the overall DMH system.

Supporting Narrative:

In July, 1992, the Participatory Planning Process was linked formally with the Office of Policy and Planning and with Program Operations. Workplans for CCSS Planning and Public Managed Care were developed. Weekly meetings of the Area Directors (Program Operations) and the Policy and Planning Committee are held to coordinate the planning of CCSS development and to further the goal of achieving a flat table of organization of Central Office and the field. Citizen participation in planning on the Area level will continue throughout 1992 and 1993. The expected outcome is an Area Plan for each Area in Summer, 1993. It is anticipated that the Area Plans for children and adults will be integrated into a new State Plan by December, 1993 and that the structure of the Area planning committees will be formalized and integrated with the state level (formerly P.L. 99-660) Planning Council. This integration has already occurred informally as the Children's subcommittee has merged with the Planning Subcommittee of the Professional Advisory Committee which is monitoring CCSS planning for children and adolescents.

C. Administration - Consumer and Community Involvement

Base Year:

- Minimal participation of parents of SED youth in DMH activities; no participation of youth themselves.

Most Recently Approved Plan (September, 1991):

- Develop an Office of Consumer Relations within DMH.

Revised or Additional 1992 Goals :

- Define and expand activities for the Office of Consumer and Ex-Patient Relations (OCER).
- Continue to support the activities of parent and professional advocacy groups.

Current Implementation/Accomplishments:

- Established the Office of Consumer and Ex-Patient Relations.
- Statewide Consumer and Ex-Patient Advisory Council established with 19 members and 19 alternates. Membership categories were determined through five consumer meetings around the state and include 9 Area representatives, 5 at-large representatives, two seats for elder consumers, two seats for adolescent consumers and a seat for a parent of a child 12 years or under. Council meets monthly. Two-day retreat on organizational development was conducted by consumer trainers on 9/3 and 9/4/92.
- First Director of OCER was hired in March, 1992 through a Search Committee with 3/4 consumer membership. He chose to return to his previous Area-based DMH position in July and the search has begun for a new Director. An Interim Director is in place.
- An 800-telephone line is operating;
  - A full-time Consumer Information and Referral Specialist responds to inquiries and complaints by consumers and contributes to system accountability
- A Mental Health Discrimination Law Project was established in collaboration with the Massachusetts Commission Against Discrimination with a full-time attorney devoted to mental health consumers who are victims of discrimination in housing, employment, education and public accommodation and a consumer advisory council. The attorney will also provide Area-based training for consumers in legal protections against discrimination.

- OCER publishes a bi-monthlyNewsletter.

- Consumers participate on every DMH board, committee and task force.

Comparison with Base Year:
Substantial growth in consumer participation in all facets of the mental health system and concomitant expansion of consumer influence and expectations.

Supporting Narrative:

The question of how best to incorporate adolescents and parents of minors in the consumer agenda continues to receive attention. The reality is that adult consumers far outweigh youth in terms of numbers and thus meeting times and agenda items tend to focus on adults. Insofar as adolescents have been able to participate, they have been welcome as consumers who can represent themselves. The Department is still struggling to assure that needs of younger children and those adolescents not yet skilled enough to speak for themselves do not get ignored in the process, and that the parents and caretakers of minors who must negotiate for services have an opportunity to have their preferences heard.

REQUIREMENT #II: The State plan shall contain quantitative targets to be achieved in the implementation of such system, including numbers of individuals with serious mental illnesses residing in the areas to be served under such system.

Determining the number of individuals in need of public mental health services for planning and service delivery purposes, and the proper targeting of an appropriate array of services to meet the articulated needs of eligible clients, requires sophisticated methods of assessing prevalence and incidence, and efficient and coordinated management information systems. DMH has utilized a nationally recognized methodology for determining prevalence and incidence but has lagged in its development of state of the art management information systems that can track service utilization and outcomes, and produce an unduplicated count of clients using DMH services. In previous years, MIS development was focused primarily on revenue generating activities such as case management and rehabilitation services. The Department has chosen **Quantitative Estimates of Target Population, Targeted Population to be Served,** and **Management Information Systems** as the indicators to demonstrate implementation of this Requirement

A. Quantitative Estimates of Size of Target Population

Base Year :

- Based on 1985 census data, and a 1976 Texas Utilization Study as quoted in Isaacs, M.R., 1983, 190,576 persons ages 0 through 21 were estimated to be at risk and in need of mental health services in Massachusetts. The number in need of public mental health services was not identified.

Most Recently Approved Plan (September, 1991):

- Utilize Prevalence estimates of the number of priority clients in each Area. After 1987, persons 19-21 became the responsibility of the Adult Services System. In the last Plan, it was estimated that of persons ages 0 through 18, 167,752 exhibited current mental illness or were at risk of future diagnosable mental illness, and that 35,540 were or would be in need of public mental services. This figure, rather than representing a specific service target for DMH, represented the total universe of clients estimated to be in need, including SED youth who would be expected to receive services through special education, the Department of Youth Services, or the Department of Social Services.

Revised or Additional 1992 Goals:

- When Summary Tape File-3 from the 1990 census becomes available (during FY'93), DMH will recalculate Area Prevalence Estimates to reflect the most current population count.

- Work with EOHHS to clarify the role of DMH in the multi-agency state structure for services to children (October 1, 1993).

Current Implementation/Accomplishments:

- State prevalence estimates were developed in 1988, based on a model developed by North Carolina which was disseminated through the Child and Adolescent Service System Program (CASSP) at NIMH. These numbers are used in the Areas for planning for the full range of children estimated to be in need of public mental health services including those served by local schools and/or DSS, DMH, and DYS.

Comparison with Base Year:
DMH successfully incorporated Prevalence Estimates into its planning. This step moved needs assessment in Massachusetts from general, abstract concepts of relative need to specific estimates of the number of youth with mental health problems in each geographic area likely to need public services.

B. Targeted Population to be Served

Base Year :

- No comprehensive client information system was in place to provide accurate data on the numbers of clients served in the categories of service. Measurement was directed primarily at inpatient utilization and case management. Note that the figures for 1987 include clients ages 19-21.
- Case management - 760 clients
- Emergency services - complete services (24 hr, 7 day) were available in only 13 of 40 Areas
- Crisis shelters - 43 slots
- Crisis respite and therapeutic family care - 23, 366 hours
- 22,696 hours of in home support funded.
- Outpatient/support - client count not available.
- Day treatment - client count not available
- Residential/housing - 271 beds
- Inpatient - 127 state funded beds, including 60 beds for children under age 16. There were 546 admissions to state funded or controlled inpatient beds.
- Long term hospital and intensive residential treatment beds - 105

- Group living/therapeutic family care - 324 beds
- Day programs - 205 slots
- Home based - 123,856 contract hours
- Outpatient - 58,763 hours

Revised or Additional 1992 Goals:

- Two revised service targets from most Recently Approved Plan (clarification of Plan submitted Dec., 1991 in response to NIMH review of September, 1991 Progress Report):

  - Case management - 820 static capacity (ages 0 through18)
  - Crisis and acute care beds - 147

  Service targets were determined based on the best information available on the impact of the FY'93 budget on mental health services for children adjusted to reflect the CCSS planning process currently underway. A new DMH plan and targets should be completed by the end of FY'93.

- Work with EOHHS to clarify the role of DMH in the multi-agency state structure for services to children and adolescents (October 1, 1993).

Current Implementation/Accomplishments:

- Case managed - 732 (end of September, 1992); waiting list of 101 with an average yearly turnover of 85%. 1,354 clients are served annually.
- Crisis and acute care beds - 66.5 (as of October, 1992; 456 admissions in FY'92)
- Long term hospital and Intensive Residential Treatment Beds - 83 (There were 58 admissions in 1992 not counting admissions to long-term care at Gaebler, since a transfer at Gaebler from acute to long-term care did not count as an admission.)
- Group living/therapeutic family care - 270
- Day treatment programs - 29,647 hours
- Day activity programs - 23,763 days
- Home based - 148,197 contract hours plus 1 state FTE who contributes approximately 660 additional hours.
- Outpatient - 83,119 contract hours plus 9 state FTE's (approx. 9,720 additional hours)
- The CCSS Area planning, which includes an extensive needs assessment, is scheduled to be completed by Summer, 1993 It will enable DMH to establish reliable targets In terms of the actual number of the target population serviced, DMH does not have clear data relating to clients who are not receiving DMH case management services.

Comparison with Base Year:
Overall, the number of clients served has increased from 1987. Despite recent budget cuts, this is a result of DMH's success in achieving its major goal of shifting resources from inpatient and residential treatment services to less restrictive yet clinically appropriate services - a home and community based service focus. The average length of stay in state-funded hospital units, for example, declined from 3.02 months in 1987 to 1.67 months currently.

Supporting Narrative:

The dramatic reduction in the category of crisis and acute care beds stems from the decision to close the Gaebler Children's Center. Children 0-14 years of age formerly hospitalized there are being cared for in private psychiatric and community hospitals, and through a variety of existing community programs. Additional community programs for children under 14 will be developed through redeployment of Gaebler dollars and through new funding the administration has committed to providing.

In addition, the Medicaid Managed Care Program took over responsibility for acute hospitalization of Medicaid clients on July 1, 1992; Thus, 30 beds which the private hospitals designated for DMH referred clients and which were included in last years totals, are no longer included. The current service count includes 7.5 "free care" beds which the private hospitals continue to allocate to DMH for use by uninsured clients.

Following completion of the CCSS needs assessment referred to above, there will be an Area participatory process to identify service system gaps and strategies to fill those gaps, as much as possible through redeployment of base resources. When CCSS planning is completed, implementation will begin. The reorganization of the service system is expected to be a multi-year process, involving the other child-serving agencies, leading to implementation of a new system of care from which the target population will benefit.

C. Information Systems or Management Information Systems

Base Year :

- Statewide inpatient database (MFR) based on manual reports by facilities
- No statewide data on community services
- State proposed to reform purchase of service system to include measures of programmatic performance.

Most Recently Approved Plan (September, 1991):

- Convene an Information Systems Planning Task Force
- Integrate MFR with the Client Registry
- Create a mainframe client tracking system

Current Implementation/Accomplishments:

- Systems Planning Task Force issued final report endorsing plans for mainframe client tracking system
- MFR in place with improved format, electronic submission from all large facilities, and merged centrally with Registry for analysis
- PC-based Client Tracking System in place for case managed clients

Comparison with Base Year:
Over the last five years, DMH has dramatically improved its client information. In 1987, statewide client data was limited to manually created inpatient databases. Today, DMH has a statewide Client Registry containing all persons receiving inpatient, case management and residential services, and a detailed tracking system for case managed clients. Plans are in place to address remaining gaps in the data management system. Standards developed for these above systems, particularly the DMH unique client ID, are beginning to be used in the numerous local client systems.

REQUIREMENT #III: The State plan shall describe available services, available treatment options, and available resources (including Federal, State and local public services and resources and to the extent practicable, private services and resources) to be provided to individuals with serious mental illnesses.

Through an extensive network of contracted programs and with some wraparound funds, the Department provides an array of services to meet the needs of children and adolescents with severe emotional distrubances. The public managed care initiative, and collaboration with Mental Health Management of America, Inc., the state Medicaid agency's vendor for mental health and substance abuse services, have positioned DMH to capture federal and private dollars. Through Comprehensive Community Support System planning and implementation, DMH plans to identify and eliminate barriers to accessible care and to significantly increase both access to and availability of emergency, crisis intervention, and treatment services. Particular attention has been focused on planning appropriate and accessible services for cultural and linguistic minority groups, court-involved youth and the deaf and hard of hearing. DMH has also made a strong commitment to ensuring that the human and legal rights of all DMH clients are protected in both inpatient and community programs. The Department has chosen **Increased Access to Services, Access to Services for Special Populations,** and **Protection and Advocacy** as the indicators to demonstrate implementation of this Requirement.

A. Increased Access to Services

Base Year

- No statewide data was collected on community services, or on total number of children using services. Statistics reflect services to youth up to age 22.
- Complete emergency services (24 hr., 7 day) available in only 13 of 40 areas
- 43 slots were available in crisis shelters.
- 22,696 hours of in-home support
- 23,366 hours of out-of-home respite and therapeutic family care
- EPSDT was not widely utilized

Most Recently Approved Plan (September, 1991):

- Provide123,856 hours of home-based/crisis intervention services available for children and adolescents up to age 19.

- Develop a centralized emergency services system for the Metro Boston Area to serve adults, children and adolescents.

- Ensure that child-trained clinicians are available in each Area to provide mental health services on a regular basis and to serve on the 24 hour crisis intervention teams. (August ,1992).

- Work with the adult service system to develop a crisis service capable of serving children for up to 72 hours, in each of the nine Areas (August, 1992).

- Assure early identification and treatment of mental health problems in children.

Revised or Additional 1992 Goals:

- Collaborate with Mental Health Management of America, Inc. (MHMA, the Commonwealth's Medicaid provider for mental health and substance abuse services) to:

  - develop additional crisis intervention/hospital diversion services (October 1, 1993).

  - develop a working agreement to ensure that mental health services and programs contracted for by MHMA meet agreed upon standards and provide access to DMH priority clients (November, 1992).

  - develop joint standards to govern emergency screening, admissions, diversionary programs, etc. for all Medicaid recipients (June, 1993).

Current Implementation/Accomplishments:

- Contracts for the current year allow for 148,197 hours of home based/crisis intervention services State staff provide an additional 660 hours of service.

- Generic emergency service teams serving both children and adults continue to function in all Areas of the state. MHMA is responsible for crisis intervention, screening and assessment of all Medicaid clients (more than 50% of the child-adolescent caseload). For the current year, MHMA is using the DMH emergency service teams. For the future, DMH and MHMA will mutually define

standards including the use of appropriately credentialed child/adolescent clinicians, and will collaborate regarding issuing of RFPs for emergency services, as DMH and the Medicaid program are committed to have a unified emergency services system. One of the major criteria in determining emergency service teams will be the availability of child-trained clinicians

- Establishment of a centralized emergency service system to serve all age groups in Metro Boston was incorporated as one of the required outcomes of Request for Proposals issued in October, 1992 by the Metro-Boston Area.

- The state's EPSDT program was audited by HCFA and found to be in compliance. The new Medicaid managed care program places the responsibility for EPSDT with Primary Care Providers or Health Maintenance Organizations, depending on which option the client has selected. DMH began discussions with Medicaid to ensure that EPSDT providers are trained and aware of their mental health screening responsibilities.

Comparison with Base Year:
Access to services has expanded over the past five years. DMH contracts for the current year for home based and crisis services have quadrupled and account for one-sixth of the children's service budget which does not factor in the percentage of DMH generic emergency dollars spent on services to children and adolescents. Home-based/crisis intervention services, augmented by crisis placements when necessary, have become a key component of the continuum of care, have decreased reliance on hospital based assessments, and have enabled DMH to provide assessment and intensive intervention services to more clients in a cost-effective, consumer friendly environment.

Supporting Narrative:

Issues of access to care at all levels is one of the key factors being examined in the CCSS process through which DMH is creating and supporting the development of a fully integrated consumer-centered continuum of care, comprised of an array of comprehensive, accessible and community-based services

B. Access to Services for Special Populations

Base Year:

- Access to services for cultural and linguistic minorities was functionally limited
- A system to serve SED youth involved with the criminal justice system was beginning to evolve
- SED youth with mental retardation were long-term patients in DMH inpatient facilities
- There was a goal of increasing specialized services for the deaf and hard of hearing
- There was no system for support of parents of SED youth.

Most Recently Approved Plan (September, 1991):

- Assure involvement of minority parents in parent support and advocacy groups.
- Advocate with Medicaid to foster the availability of culturally and linguistically appropriate mental health services through its Regional Management Centers.
- Recruit and retain multi-cultural staff.
- Develop and implement a work plan for improving cultural competency of the chid-adolescent service system and service providers (September,1992)

Revised or Additional 1992 Goals:

- Incorporate the needs of special populations in the Area needs assessments completed as part of the CCSS planning process (October 1, 1993).
- Establish a permanent mechanism to monitor the operations of private agencies and organizations who have contracted with DMH to ensure the cultural and linguistic needs of DMH priority clients are being met (October 1, 1993).
- Amend DMH regulations, operational policies and practices, including review of all RFP's, to meet the mandate of the Americans with Disabilities Act of 1990 (October 1, 1993).

Current Implementation/Accomplishments:

- Nine parent support groups are now functioning, and more are in process
- The Metro Boston Area and City of Lynn are organizing parent support groups for minority parents. In Metro Boston, the Parent/Professional Advocacy League (PAL) will provide consultation on parent involvement for planning to be conducted as part of an Urban Mental Health Initiative funded by the Casey Foundation. PAL is funded in Lynn to set up a group for Spanish-speaking parents.
- The Federation for Children with Special Needs, of which PAL is a part, is establishing a staff presence at the Dimock Community Health Center, in the heart of the African-American community in Boston, in order to facilitate outreach to minority parents.
- DMH convened two statewide meetings regarding access to services for the minority community and created a statewide Multi-cultural Advisory Committee (See details under Requirement #I/Planning) This committee will carry out the functions originally envisioned as part of a workplan

- EEO/AA staff participated in the review of all DMH RFP's to ensure consideration of the special needs of culturally and linguistically diverse populations and the specific requirements of the disabled client.

- The DMH Minority Subcommittee for Child-Adolescent Services reviewed Medicaid draft proposals to ensure consideration of the special needs of culturally and linguistically diverse populations.

- DMH has monitored workforce statistics to insure equitable distribution of protected group employees by EEO job category through the application of the Provider Workforce Utilization/Goal Setting Summary. Quarterly reviews are established for agencies found to have hiring deficiencies, i.e. less than goal parity for minorities, women, and the disabled, with special emphasis given to high level positions and board membership.

- Multi-Cultural Advisory Committee established as part of the statewide CCSS process meets monthly to address access issues.

- DMH has expanded services in the community to meet the needs of cultural and linguistic minorities (see specifics in Supporting Narrative).

- DMH has a contract mechanism under which it hires interpreters for youth and/or family members who are non-English speaking or deaf or hard of hearing.

- DMH shares the cost with the Department of Mental Retardation and the Department of Social Services for 15 mentally ill, mentally retarded adolescents in a program developed by the three agencies.

- To assure appropriate service for court involved youth, child psychologists or psychiatrists with a forensic specialty are assigned to most courts. Clinical experts are available as needed for the few courts without assigned clinicians.

- A Deaf and Hard of Hearing Mental Health Advisory Committee was formed which includes the staff of the Massachusetts Commission for the Deaf and Hard of Hearing, consumers, DMH staff, and mental health professionals specializing in deaf services. It meets at least once a month to address access issues and make recommendations to the Department. Its principles for achieving communication access for the deaf and hard of hearing were incorporated into the "Guidance Manual for Area Participatory Planning", and individuals interested in mental health services for deaf and hard of hearing mentally ill have been contacted and encouraged to participate in Area participatory planning.

- In February, 1992, in order increase access to services, DMH re-issued to all emergency services providers the procedures for referrals to the statewide inpatient unit which serves deaf and hard of hearing adolescents and adults.

- DMH continues to make available its Community Mental Health Services for Deaf and Hard of Hearing Persons Resource Directory (June, 1990) as part of the effort to ensure access

- In January, 1992 DMH and New England Telephone Company collaborated on an updated TTY directory.

Comparison with Base Year:
Significant steps have been made since 1987 to improve access to existing mental health services for individuals and populations with specialized needs. Examples of progress are the planning effort to establish Comprehensive Community Support Systems (CCSS), initiation of the Multi-cultural Advisory Committee, the extension of the mandate to meet requirements for services to cultural and linguistic groups to hospitals and agencies contracting to provide services, the concerted outreach to involve parents of minority clients in parent support and parent advocacy efforts, and in collaborative service development for youth who are mentally retarded and mentally ill.

Supporting Narrative:

DMH provides funds for interpreter services to clients on DMH inpatient units as well as in some non-acute settings such as day treatment, outpatient, residential programs, and meetings with case managers Statistics are not broken down by age categories, but interpreter services have been provided for the following groups of clients and families: deaf and hard of hearing (150 clients) Vietnamese (35), Cambodian (35), Portuguese (13), Spanish (12), Haitian (10), Italian (1), Chinese (13), Albanian (3), Cape Verdean (2), Russian (1), Arabic (2), Japanese (1), Greek (1), and Polish (1). Total expenditures for FY'92 were $36,421 compared to $13,355 in FY'90.

Programs which specifically serve minority populations include:
Metropolitan Indo-Chinese Child and Adolescent Services (Boston and Lynn)
Haitian Mental Health Unit (Cambridge)
St. Ann's Home (Lowell)
South Cove Community Health Center (Boston)
Inquilinos Borecuras en Accion (Boston)
Alianza Hispana (Boston)
Dorchester Counseling Center (Boston)
Gandara Mental Health Center (Western Mass)
Roxbury Youth Works, Inc. (Boston)
Spanish-American Center, Inc. (Leominster)

C. Protection and Advocacy

Base Year:

- No Central Office human rights staff was available to provide significant support, training or advice to field staff (including human rights officers, human rights committees and other staff) concerned about human rights issues. There were no statewide human rights conferences or trainings

- In 1986, DMH promulgated Regulations (104 CMR 24.00) which set forth guidelines for the investigation of consumer, family or advocate complaints. The Office of Internal Affairs was established to oversee the complaint and investigation process.

Most Recently Approved Plan (September, 1991):

- Ensure the human and legal rights of clients in all of its facilities and programs, and overall coordination of issues and policies related to human rights through appointment of a Special Assistant for Human Rights.

- Ensure that any complaint alleging dangerous, illegal or inhumane incidents or conditions is investigated or otherwise resolved (reaffirmation of previous commitment).

Revised or Additional 1992 Goals:

- Extend the DMH commitment to ensuring the human and legal rights of clients to all contracted community service programs (FY'92/93).
- Continue to implement structural changes in the Office of Internal Affairs (OIA) (by October 1, 1993).

Current Implementation/Accomplishments:

- The DMH Central Office Special Assistant for Human Rights meets regularly with and communicates often by telephone with inpatient human rights officers to provide them with direction, support and advice. Training is provided informally as well through statewide conferences twice a year, and locally-based training events.

- Handbooks were produced and distributed regarding (i) rights of clients in the community, (ii) role and responsibilities of the human rights officer, and (iii) role and responsibilities of a human rights committee.

- In 1992, the Department conducted a thorough analysis of the complaint/investigation process (OIA) and identified a number of areas which could be strengthened. A new structure was established and a process was initiated which ensures objectivity in the conduct of investigations and the integration of the results of complaint/investigations with quality management, human rights, human resources, fiscal and contracting activities within the Department

- Management information reports are produced on a monthly basis to apprise interested persons of the categories of complaints received by the Department and to monitor the timeliness of completion of investigations.

Comparison with Base Year:
Since 1987 DMH has increased its training and supervision of human rights officers and human rights committees; expanded its involvement in human rights compliance to cover contracted community services; held regular human rights conferences; and prepared reference guides for hospital and community staff regarding the human and legal rights of clients.

As a result of the 1992 reforms, OIA reports directly to the Commissioner. All investigations of complaints by staff, consumers, family members, advocates and other mandated reporters are supervised by OIA and conducted by trained and certified investigators who are not affiliated with individual facilities. Previously, investigators were based at each DMH facility where a significant percentage of the complaints originated, some investigations were overseen by the Areas, and not all personnel performing the investigations received specialized training.

To reinforce objectivity, DMH has taken steps to ensure that decision letters directing corrective action in response to complaints are prepared by DMH Area Directors rather than facility heads or community program directors. These letters are reviewed by Central Office senior management staff to monitor the appropriateness and timely completion of recommended actions and to determine if there are statewide training and/or policy implications.

REQUIREMENT #IV: The State plan shall describe health and mental health services, rehabilitation services, employment services, housing services, educational services, medical and dental care, and other support services to be provided to children with serious emotional and mental disorders with Federal, State and local public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

As the Department completes the restructuring of its service delivery system and the implementation of public managed care, it will continue to develop and support an integrated array of programs and services that are designed for severely emotionally disturbed children and adolescents and their families, to enable the youth to remain in their own homes and communities. This entails maintaining existing, proven service models and developing new ones that are responsive to family needs and preferences. The closing of the Gaebler Children's Center has enabled DMH to redeploy funds toward community based services for children under 14 For adolescents, group living beds have been reduced and home-based and outpatient treatment services increased. DMH has used the CASSP grant to develop a model for interagency coordination and service delivery, to improve services to minorities, and to make the system more responsive to families through the establishment of peer support groups and through strengthening the role of parents in DMH policy and planning. The Department has chosen **Extent and Availability of Services**, **New Service Programs** and **Relations with Other Programs** as the indicators to demonstrate implementation of this Requirement.

A. Extent and Availability of Services

Base Year:

(Figures for the base year reflect services to clients through age 21)

- Emergency services complete in 13 of 40 Areas
- Case management - 760 clients
- Crisis shelters - 43 slots
- Crisis respite and therapeutic family care - 23,366 hours
- In-home support - 22,696 hours
- Outpatient - 113,327 hours

- Day treatment - capacity of 271 clients
- Residential - 271 slots
- Inpatient - 127 state funded beds

Most Recently Approved Plan (September, 1991):

Service Targets:

- Case management - 820 in a sample month
- Crisis and acute care beds - 147
- Long term hospital and intensive residential beds - 105
- Group living/therapeutic family care - 324 beds
- Day programs - 205 slots
- Home-based treatment - 123, 856 hours
- Outpatient - 58,763 hours

Revised or Additional 1992 Goals:

- Determine the availability, gaps, and need for specific services in each approved natural service area through the Area Participatory Planning Process, including consultation with other state child-serving agencies. Base design of each CCSS on this assessment and match with available resources to provide at least those services which are determined to be essential to a CCSS. Build on this foundation as resources become available to create the optimum service configuration and capacity for each natural service area (FY '93-'94).

- Establish 2 secure intensive residential treatment programs, of 10 to 12 beds each, to serve children under the age of 14 who previously were treated by long term hospitalization at the Gaebler Children's Center.

- Establish 2 long-term hospitalization programs,of 12 beds each, to serve children under the age of 14 who previously were treated by long term hospitalization at the Gaebler Children's Center.

- Continue initiatives to replace hospital and residential programs with intensive home and community services to the extent clinically appropnate (FY 92/93).

- As part of the restructunng of the mental health system, evaluate the current DMH case management system Pending the outcome of this evaluation, make recommendations regarding case management model(s) and numbers of persons to be served. This, in conjunction with the CCSS planning process and Area needs assessments should enable DMH to more carefully target its case management resources (FY'93-FY'94)

Current Implementation/Accomplishments:

- Case management - 732 (9/30/92); waiting list of 101. Dynamic annual capacity of 1,354.
- Cnsis and acute care beds - 66.5
- Long term hospital and intensive residential treatment beds - 83
- Group living and therapeutic family care - 270 beds
- Day treatment programs - 29,647 hours
- Day activity programs - 23,763 days
- Home-based treatment - 148,857 hours
- Outpatient -92,939 hours
- Cnsis and acute care beds were dramatically reduced, as a function of: 1) the decision to close the acute care beds at the Gaebler Children's Center, and have children receive acute inpatient care in private psychiatric facilities and general hospitals 2) assumption by MHMA of the responsibility for screening and acute hospitalization of most Medicaid clients.
- Long-term care beds were reduced by the closing of the long -term care beds at the Gaebler Children's Center. RFPs were issued for secure intensive residential treatment programs and community residential treatment programs to serve children under 14 who were previously hospitalized for extended penods of time at Gaebler .
- Group living beds were reduced as a function of the decision to shift resources to in-home treatment. Thus, the increase in hours in home-based and outpatient was significantly greater than anticipated.

Comparison with Base Year:
Complete emergency services are now available in every Area. Home and community based treatment has expanded significantly . DMH succeeded in its major planning goal of shifting the balance of resources from restrictive inpatient and residential care toward less restnctive yet clinically appropnate community based treatment.

Supporting Narrative:

The case management numbers did not increase as expected. In part, this may be due to staff turnover caused by a new civil service list, and the requirement that people in case management supervisory positions be on that list. Also, for the first time there was a waiting list, reflecting Area decisions to keep manageable caseloads, rather than carrying more cases than could be serviced well. In light of the above considerations, and given monthly variations, the target figure for complete implementation in 1993 is being revised to a static capacity of 730.

B. New Service Programs or Relations with Other Programs

Base Year:

- CASSP grant was awarded in 1987. Focus of the grant was on treatment of seriously emotionally disturbed youth within Health Maintenance Organizations and by private insurers, based on the knowledge that unless the private sector met its responsibilities to insured clients, the public sector would become overwhelmed by clients not considered within its target planning population. As the grant progressed, additional goals related to parent support and empowerment, interagency coordination, and minority involvement were added.

Most Recently Approved Plan (September, 1991):

- Continue initiatives of CASSP grant.

Revised or Additional 1992 Goals:

- Develop models for early intervention and comprehensive service delivery including a single case management system, integrated intake, linkage with Medicaid covered services, and integration of school and community services through activities to be conducted under the Casey Urban Mental Health Initiative Planning Grant awarded in June, 1992 (by October 1, 1993)

Current Implementation/Accomplishments

- The Division of Insurance issued guidelines developed in conjunction with CASSP staff outlining the responsibilities of insurers, including HMOs, in regard to screening, crisis intervention, hospitalization, and treatment of "chronic" patients.

- As a result of educational outreach by CASSP staff as well as market forces, insurers are now routinely funding hospital diversion services and day treatment as alternatives to hospitalization The state's mandated mental health benefit was revised to allow for alternatives to hospitalization

- Nine parent support groups began operating within the past year based on a Families as Allies model. Three parents work part-time as parent coordinators. In addition, AMI agreed to pursue an AMI-CAN (Children and Adolescent Network) initiative in Mass. and there are 2 AMI-CAN support groups. Plans have been formulated for intensive outreach to minorities

- The CASSP interagency demonstration project in the City of Lynn successfully brought the local school system and state agencies together to do service planning for multi-agency involved children, and demonstrated the effectiveness of flexible funding for individualized services. The project is being continued with state funds. Information gained from this project and from the CASSP training on local systems of care are being integrated into the CCSS planning process.

- Plans for outreach to minority parents in Lynn and Boston were developed and funding allocated.

- New program development will follow from the CCSS planning process. The second phase will include the use of a uniform needs assessment tool. Standards regarding minimum service systems will be applied to existing service systems in each Area.

- Multi-year Area plans, developed as a result of the CCSS planning process, will identify unmet needs and thereby facilitate more extensive exploration of new program models. Information about new program types will be shared to assist Areas in creative thinking about ways to address consumer needs more effectively.

REQUIREMENT #V: The State plan shall describe the financial resources and staffing necessary to implement the requirements of such plan; including programs to train individuals as providers of mental health services, and the plan emphasizes training of providers of emergency health services regarding mental health.

A transition in service organization and redistribution of resources to reflect a more flexible system of comprehensive community based services is taking place at DMH. Reduction in the length of inpatient stays and a decreased reliance on residential treatment in favor of home-based, day and outpatient treatment is enabling DMH to develop additional community capacity. The capacity to generate Medicaid revenue, which has been increasing since 1987, has enabled DMH to sustain services despite financial limitations. DMH recognizes that in order to promote high quality services it must attend to the system's human resources, increase the representation of minority professionals to better address the needs of diverse communities, and institute a training program for DMH and provider staff. DMH has chosen **Funds Available for Community Programs**, **Availability of Human Resources**, **Medicaid Funds**, and **Training** as the indicators to demonstrate implementation of this Requirement.

A. Funds Available for Community Programs:

Base Year:

- 19.0% of budget spent on inpatient services (does not include the state-operated Gaebler Children's Center which was funded from the Hospital Management Account)
- 64.8% of budget spent on community programming
- $0 in revenue generated by Medicaid reimbursement for case management, Psych Under 21, and Rehabilitation Option.
- Total state dollars in children's account - $30,424, 567.

Most Recently Approved Plan (September, 1991):

- Ensure fiscal resources to
  - Implement a system of Public Managed Care
  - Complete the Comprehensive Community Support System
  - Shift resources from inpatient/institutional to outpatient/community based services

Current Implementation/Accomplishments:

- 12.8% of budget spent on inpatient services (for comparability, this does not include the Gaebler Children's Center which closed September 30, 1992).
- 80.1% of budget spent on community based services
- $3.4 million generated by billings for Psych Under 21 and $2.3 million for Rehab Option. $8.6 million, including services for children and adults, generated by billings for case management in FY'92.
- Total FY'92 budget for child and adolescent services - $45,485,201.

Comparison with Base Year
DMH reduced the percentage of dollars spent on state hospitals and redeployed dollars to community programs Revenue is generated by case management, inpatient and residential treatment programs. Overall funding for children's services has increased. An additional $15 million is clearly earmarked for children, although not all of this represents an absolute increase, as, in the past two years, children's dollars which were in other accounts have been identified and reallocated to the children's account for greater accountability.

B. Availability of Human Resources

Base Year:

- Very low unemployment in Massachusetts
- High staff turnover in state-funded agencies @90%
- Human service jobs hard to fill
- Focus on recruitment, retention, utilization and training of workforce, and development of H.R. management information system.

Most Recently Approved Plan (September, 1991):

- Ensure human resources to:
  - Implement a system of public managed care;
  - Complete the Comprehensive Community Support Systems

- Ensure that recruitment, hiring and training policies improve the cultural/linguistic diversity of staff to meet the needs of a varied clientele.

Revised or Additional 1992 Goals:

- Ensure that review of RFPs, final contracts, and contract renewal proposals address the needs for cultural and linguistic diversity of staff to meet the needs of a varied clientele.
- Computerize the records, files and documentation for contracting and affirmative action program functions (October 1, 1993).
- Continue and expand, if possible, DMH recruitment efforts with advocacy groups and community agencies, college and universities with significant minority/women representation.
- Increase the representation of minority professionals.
- Increase representation of parents of SED youth in the workforce (October 1, 1993)

Current Implementation and Accomplishments:

- All RFP's reviewed for capacity to respond to cultural and linguistic needs of the clientele
- Workforce statistics monitored to insure equitable distribution of protected group employees by EEO job category through the application of the Provider Workforce Utilization Analysis/Goal Setting Summary. Quarterly reviews are established for agencies found to have hiring deficiencies, i.e. less than goal parity for minorities, women and the disabled, with special emphasis given to high level positions and board membership.
- Consultation provided to three applicant organizations for NIMH clinical training grants related to work with SED children and/or training of minority staff.
- Consultation provided to a graduate school of social work around curriculum development to meet the changing demands of child-adolescent treatment.
- On September 30, 1992 the Gaebler Children's Center, the only state-operated facility for children under 14, closed after all remaining patients were transferred to other community or residential settings In the process of closing the hospital, DMH placed significant emphasis on addressing the needs of employees affected by the closing These human resources initiatives included aggressive outplacement, transfers to other DMH facilities or other state agencies and counseling, as needed, regarding retirement options.

SUMMARY OF ATTRITION OF GAEBLER EMPLOYEES
NOVEMBER, 1992

VOLUNTARY LAYOFFS	56
BUMPS/REASSIGNMENTS WITHIN DMH	15
RETIRED	9
TRANSFERRED INTO VACANCIES	13
LAID OFF	7
TRANSFERRED TO OTHER STATE AGENCY	1
RESIGNED	5
	124 FTE'S
FILED FOR UNEMPLOYMENT COMPENSATION	21

Comparison with Base Year:
The development of human resources to increase access to services for special populations improved markedly , particularly as related to cultural and linguistic minorities. There is now increased diversity of the state work force - particularly among case managers. Given that most services, however, are provided through contracts with private providers, continued progress is dependent on training the private sector workforce, through continuation of activities begun as part of the quality management initiative

C. Medicaid Funds:

Base Year:

- DMH submitted an amendment to the Medicaid State Plan to allow billing for targeted case management services.
- $0 revenue from case management services
- $0 revenue from Rehabilitation Option billing
- $0 revenue from Psych Under 21 billing

Most Recently Approved Plan (September, 1991):

- Increase revenues by billing Medicaid for targeted case management and rehabilitation option
- Work with the legislature to allow continued revenue retention by DMH
- Develop legislation allowing DMH contracted services providers to receive third party revenue including Medicaid and Medicare, as an offset to state program costs rather than requiring DMH to generate non-tax revenues for the General Fund.
- Work with providers to implement the above revenue initiative.

Revised or Additional 1992 Goals:

- Continue revenue initiatives with the exception of pursuing the goal of retained revenue The legislature eliminated this practice for executive agencies.

Current Implementation/Accomplishments:

- $8.6 million/year generated from case management services (includes children and adults).
- $2.3 million/year generated from Rehab Option services
- $3.4 million/year generated from Psych Under 21 services.

Comparison with Base Year:
Department generated Medicaid revenue has become a key ingredient in the funding of mental health services since 1987. During the period when DMH was allowed to retain the revenues generated by Medicaid funding, this funding was used for program expansion despite level funding by the state. later, as the base budget was cut, the federal reimbursement was used to offset the impact of the cuts.

Supporting Narrative:

Due to changes in the state budget enacted by the legislature, DMH does not retain the revenue from current children's programs, and the plan to have contracted providers bill Medicaid directly for Rehab Option services was not supported. However, the administration agreed that when the Gaebler Children's Center closed, it would support a budget which allowed DMH to receive an allocation as part of its base budget equivalent to the federal revenue expected to be generated by the new programs established to serve Gaebler clientele.

E. Training

Base Year:

- No core training curriculum in place
- No training provided for consumers and advocates

Most Recently Approved Plan (September, 1991):

- Provide training for case managers on a variety of topics relevant to serving SED youth and require all new case managers to complete four day overview training Case manager training is discussed more fully in Requirement VII

- Provide training to DMH staff regarding implementation of various quality assurance mechanisms (See Requirement I).

- Provide training to Area planning committees regarding design of the Comprehensive Community Support Systems (see Requirement I).

Revised or Additional 1992 Goals:

- Hire a DMH Director of Training (FY'92)
- Catalog and coordinate all training efforts being offered by DMH, state and vendor agencies (October 1, 1993).

- Develop a Core Curriculum emphasizing the role of the consumer and families of minors and including a module on culturally competent service delivery (by October 1, 1993).

- Develop plan to teach the Core Curriculum to every DMH and vendor employee (by October 1, 1993).

- Plan Human Resource Development training for senior DMH staff (including Area Directors) with Human Resource Associates of Western Massachusetts, an NIMH funded organization (FY'93).

Current Implementation/Accomplishments:

- Training sessions were conducted for each of the nine Area planning committees to prepare for CCSS planning and system design during 1992.

- Trainings in Total Quality Management have begun.

- Trainings were conducted for case managers on access to SSI including the Zebley changes, and on access to the state Medicaid program.

Comparison with Base Year:
Training in all areas increased significantly. With the hiring of a DMH Training Director and the coordination of training efforts, it is anticipated that DMH resources will be used more productively, and that policy initiatives will be translated more effectively into practice.

REQUIREMENT #VI: The state plan shall provide for activities to reduce the rate of hospitalization of individuals with serious mental illnesses.

DMH has achieved a reduction in the rate of hospitalization of children and adolescents with severe emotional disturbances through improved monitoring and reporting mechanisms for screening, admission, utilization and discharge, continued development of community alternatives, and improvement in the emergency services system. The collaboration with MHMA, Inc., the Medicaid mental health and substance abuse vendor, to develop additional community diversion services should also have a significant effect on reducing the rate of hospitalization, as should the collaboration with the Division of Insurance to develop regulations promoting the use of alternatives to hospitalization by private insurers. In addition, identification of services needed by families to enable SED youth to be treated while living at home, should also reduce the rate of hospitalization. DMH has chosen **Clients in State Hospitals** and **Programmatic Initiatives to Reduce Hospitalization Rates** as the indicators to demonstrate implementation of this Requirement.

A. Clients in State Hospitals

Base Year:

- 127 DMH funded beds, including 60 beds for children at the Gaebler Children's Center.
- 546 admissions to state funded or controlled inpatient beds
- Average length of stay for adolescents in DMH funded or controlled beds - 208 days
- Average length of stay for children under 16 at Gaebler Children's Center - 91.8 days
- First private psychiatric facility certified as Psych Under 21 provider in April ,1987.

Most Recently Approved Plan (September, 1991):

- Explore feasibility of HCFA certification for the Gaebler Children's Center

Revised or Additional 1992 Goals:

- Prepare recommendations about the future Gaebler Children's Center and services for children under age 14 for the Special Commission on the Consolidation of Health and Institutional Facilities (April,1992)

Current Implementation/Accomplishments:

- 43 DMH funded or controlled hospital beds for adolescents.
- 514 admissions in 1992 to DMH funded or controlled inpatient beds.
- 7.5 free care beds in the private psychiatric facilities available for DMH children and adolescents.
- Gaebler Children's Center closed September ,1992.
- Average length of stay in DMH funded or controlled units reduced to 38 days.
- Eight private psychiatric facilities certified as Psych Under 21 Medicaid providers.

Comparison with Base Year:
The number of DMH funded or controlled hospital beds was dramatically reduced due to the closure of the Gaebler Children's Center, the reduction in average length of stay through aggressive case management, and the increased willingness and capacity of the private psychiatric facilities and general hospitals to serve SED youth.

B. Programmatic Initiatives to Reduce Hospitalization Rates

Base Year:

- Emergency services, including screening, complete (24 hr./7days/wk) in 13 of 40 areas.
- Respite/hospital diversion services not available in each area.
- No regular monitonng of length of hospital stay.
- In 1987, Determination of Need (DoN) guidelines were in place for establishment of new beds in pnvate psychiatric facilities, but no formal arrangement existed between DMH and DPH to approve

general hospital requests for psychiatric beds. On 6/20/89 DPH adopted DoN Guidelines for Conversion of Acute Care Beds to Inpatient Psychiatric Beds requiring applicants to demonstrate commitment to serve DMH priority clients and to a working agreement with DMH as a condition of approval.

Most Recently Approved Plan (September, 1991):

- Monitor hospital use (DMH funded or controlled beds and Psych Under 21 admissions) and residential stay (in DMH funded facilities) of children and adolescents through participation of DMH staff in the admission, case review and discharge process.
- Identify the number of respite beds and the configuration of respite and hospital diversion services needed in each Area through the CCSS planning process
- Support legislation amending the insurance law to cover previously non-covered mental health services.

Revised or Additional 1992 Goals:

- Identify the number of respite beds and the configuration of respite and hospital diversion services needed in each area through the CCSS planning process (October 1, 1993).
- Work with the Medicaid managed care program to increase availability of diversionary services

Current Implementation/Accomplishments:

- DMH continues to manage and monitor hospital use by non-Medicaid and Medicaid clients not eligible for the Medicaid managed care program.
- The CCSS needs assessment process currently underway is identifying the respite care needs in each CCSS.
- Recently enacted health care legislation includes a provision directing the Division of Insurance to allow substitution of community alternative services (i.e. diversion, day treatment, etc) for the state-mandated inpatient psychiatric benefit for clients who are privately insured DMH presented testimony to DOI regarding implementation of this provision especially emphasizing the use of community diversion and intensive home-based intervention as acceptable and desirable alternatives to hospitalization for children.

- DMH is currently engaged with Medicaid's managed mental health and substance abuse managed care vendor, Mental Health Management of America (MHMA) to expand diversionary services (December , 1992).

Comparison with Base Year:
Emergency Services are now complete in all 9 Areas (1990 reorganization reduced the number of areas from 40 to 9). Each Area has holding beds and some diversionary capacity. A rigorous system of screening for hospitalization, case review, and case manager involvement in discharge planning significantly reduced the number admissions to hospitals and the length of stay. Both the Medicaid system and private insurers also increased relying on and thus purchasing services from community programs as an alternative to hospitalization or as a means of shortening the length of hospital stays.

Supporting Narrative:

MHMA and DMH are planning to use the same emergency screening teams in order to screen and divert admissions and create a seamless system. Joint contracts will be negotiated with these teams. DMH and MHMA will also be seeking to reduce length of stay through short term case management from inpatient care and linkage to community based care.

The CCSS reorganization should also contribute to further reduction in hospitalization rates, as better supports will be able to be provided to children and their families in the community in accordance with their needs and preferences.

REQUIREMENT#VII:

(A) The State plan shall require the provision of case management services to each individual with a serious mental illness in the State who receives substantial amounts of public funds or services.

(B) The State plan provides that the requirement of sub-paragraph (A) will not be substantially completed until the end of fiscal year 1993.

As DMH has moved to restructure its service delivery system and implement public managed care within comprehensive community support systems, the focus on models of case management, locus of service provision and target population for these services has intensified. There is an active and ongoing examination of the case management model developed in 1987, primarily an "enhanced brokerage" model, and interest in modifying the model to also include intensive clinical case management and the use of consumer case managers to augment the current state-operated system. DMH has substantially increased the number of case managers and revised its case management services since the beginning of planning under P.L.99-660 but must continue to ensure that the model supports the changing service system. Providing ongoing training for case managers is also a priority. DMH has chosen **Population Receiving Case Management Services**, **Case Management Training** and **Case Management Model** as the indicators to demonstrate implementation of this Requirement.

A. Size of Population Receiving Case Management Services

Base Year:

- Policy on case management services issued April, 1987
- At least one children's case manager assigned to each DMH area.
- 760 clients served (includes clients through age 21)
- Average caseload approximately 1:25

Most Recently Approved Plan (September, 1991):

- Serve 820 clients a month

- Maintain case manager:client ratio at no greater than 1:25
- Maintain case management services for the most severely disabled.

Revised or Additional 1992 Goals:

- Reach agreement with Medicaid about respective agency responsibilities under the Medicaid managed care program with MHMA.

- Devise recording system to assure an accurate count of children receiving case management services, whether such services are provided on a short-term or a long-term basis.

- Establish a target of clients to receive case management services, and the model(s) of service to be provided through the CCSS planning process.

- Serve 1450 clients during the course of a year.

Current Implementation/Accomplishments

- Case manager: client ratio has been maintained at less than the maximum of 1:25. The ratio varies by Area from 1:12 to 1:20.

- Active caseload as of September,1992 was 732 (1,354/year). (101 on waiting list)

Comparison with Base Year:
A full children's case management system was in place in 1987. The number of children to age 19 receiving case management services has not changed significantly, given that the1987 figures include children through age 21, and current figures include only those through age 18. Despite budget cuts, DMH has been able to reduce caseloads and provide intensive services to those most in need.

Supporting Narrative:

Although DMH succeeded in giving priority to the most disturbed clients, fewer children than predicted received case management services in 1992. An analysis of the data suggests the following reasons 1) Staffing: Due to budget constraints there was a temporary hiring freeze in the fall Also, a civil service list was issued for Case Manager Supervisors III, resulting in additional hiring delays and reassignments of people who were bumped from their positions. New staff do not pick up a full caseload immediately 2) Recording It appears that many clients who are receiving short term case management services are not being recorded, however, the system will soon be standardized across Areas 3) Increase in waiting list- In order to highlight staff shortages, case manager supervisors are placing children on waiting lists, rather than increasing caseload size. The target for 1993 will reflect the work being done on the case management model (see C below) and the CCSS needs assessment.

B. Case Management Training

Base Year:

- Training was provided to all case managers regarding the philosophy and principles of the new case management policy. Additional training was provided regarding ISP regulations and ISP preparation. A comprehensive curriculum and training guide for case managers was prepared in 1989.

Most Recently Approved Plan (September, 1991):

- Provide training for case managers on a variety of topics relevant to serving seriously emotionally disturbed youth and require all new case managers hired to complete the four day overview training.

- Provide training to increase access to SSI entitlements.

Current Implementation/Accomplishments:

- Case Management training in DMH is decentralized by Areas to be fully responsive to the needs of consumers in their communities. Trainings, therefore, are guided by Central Office general directive and Area specific need.

- In 1992, statewide training was provided for case managers on the following: role-enhancing basic case management skills (ISP, human rights, etc.); access to Medicaid for persons 18-21, the implications of the Zebley decision on application for SSI benefits

- In addition to statewide trainings, Area level on-going supervision for case managers is provided and various Areas emphasize further specific need. In 1992 for example, training on ISP planning took place in 3 Areas.

- As the DMH Core Curriculum is developed in the coming year, case managers will be able to participate in statewide training related to the Core Curriculum topics

Comparison with Base Year:
Case management training is more topic specific and is focused on Area identified consumer needs There is an increased focus on cultural competency and on access to entitlements and services from other agencies, including financial support for clients and special education

C. Case Management Model

Base Year:

- The DMH case management policy (#87-3) was developed in 1987.

Most Recently Approved Plan (September, 1991):

- Establish a workgroup to study models of case management.

Revised or Additional 1992 Goals:

- Incorporate planning for case management in CCSS planning process.

Current Implementation/Accomplishments:

- A workgroup was established in January, 1992. Preliminary report sent to Commissioner in May, 1992 recommended actions for Area case management development, program evaluation and data collection.

Comparison with Base Year:
DMH is re-assessing the case management system it developed in 1987 and will recommend changes, as necessary, to the Commissioner. These will be implemented as CCSS planning proceeds.

Supporting Narrative:

In January, 1992, a workgroup comprised of DMH staff was established to look at the current "brokering" case management model and compare it to a "level of care" case management model. Membership was soon expanded to include consumers and family members. It became clear that the current system is augmented by a variety of activities that are considered to be case management in each of the Areas. It also became clear that evaluation of the current system would require additional time as well as input from Area Directors.

In July, 1992 a decision was made to incorporate case management planning into the ongoing CCSS participatory planning process. This process involves a description of models, data collection and identification of recommended new directions for program planning as an ongoing process to improve services to seriously mentally ill and severely emotionally disturbed children. By incorporating case management planning into the CCSS process, DMH will develop a clear picture of functions as well as programs and determine how these do or do not meet the needs of DMH consumers. Plans due in Summer, 1993 will include recommendations regarding case management. DMH expects to maintain case management as a state-operated program to ensure accountability.

REQUIREMENT #VIII: The State plan shall provide for the establishment and implementation of a program of outreach to, and services for, individuals with serious mental illnesses who are homeless.

Massachusetts has assigned primary responsibility for services to homeless children and adolescents to the Department of Public Welfare and to a lesser degree, the Department of Social Services. To support the 1992 initiative to close and consolidate several state hospitals for adults, DMH restricted its outreach efforts for the homeless or those at risk of homelessness to single adults. There were no formal outreach activities directed toward children or adolescents. As a result of CASSP initiatives with shelters serving runaway and homeless youth, ongoing advocacy efforts and internal review, DMH has reassessed its implementation priorities and decided, in spite of continuing budget issues, to reinstate these efforts to serve homeless children and adolescents. In addition, DMH has asked the Executive Office of Health and Human Services Task Force on the Homeless to address the needs of homeless children and adolescents and to outline an interagency action plan for comprehensive services to this population. DMH has chosen **Population Served**, **Homeless Programs** and **Planning** as the indicators to demonstrate implementation of this Requirement.

A. Population Served

Base Year:

- No specific count of the number of homeless mentally ill served. No specific DMH services targeted to homeless families with children. Department of Public Welfare has primary responsibility for family shelters.

- Homeless and runaway youth defined as the primary responsibility of the Department of Social Services.

Most Recently Approved Plan (September, 1991):

- Maintain mental health prevention and intervention services to homeless children and families in Metro Boston, the Area with the greatest concentration of homeless families

Current Implementation/Accomplishments:

- Given budget limitations, and the desire to address the housing needs of persons being discharged from state hospitals, DMH focused its services in1992 on persons who met the DMH priority clientele criteria for serious mental illness. Thus, there was no regular outreach and consultation to family shelters. Services are available, however, to particular children and adults in family shelters if they are identified as seriously mentally ill. Subsequently, a decision was made to reinstitute these outreach and consultation services

Comparison with Base Year:
A report was prepared on the psychosocial needs of homeless children and families. During the past five years family shelters received case consultation and technical assistance on the development of programs and playspaces for children. The primary responsibility for homeless families remains with the Department of Public Welfare, with the Department of Social Services sharing some responsibility.

B. Homeless Programs

Base Year:

- Limited outreach to homeless families with children.

Most Recently Approved Plan (September, 1991):

- Provide educational and experiential learning groups for parents in homeless families in Boston (August ,1992).
- Provide training in Metro-Boston Area to staff of shelters and community agencies around creation of positive environments and early detection of mental health problems. (August, 1992).
- Conduct statewide training for case managers (December, 1992).

Revised or Additional 1992 Goals:

- Establish outreach services to children and parents in shelters serving homeless families. Provide consultation and training in child mental health to staff of these shelters.
- Revise statewide training to target Area Directors and Area Children's Directors to facilitate planning for the homeless within the context of CCSS planning (Winter, 1993)

Current Implementation/Accomplishments:

- Collaborative relationship maintained with the Boston Children's Museum whereby 5 workshops on mental health issues have been held for shelter residents and staff of the museum. Locating services in the museum also offers parents a chance for experiential learning.

Comparison with Base Year:
Extensive community work done until this past year with neighborhood clinics and schools to enhance service delivery on behalf of homeless families with children Massachusetts completely met initial targets for services to the population. However, due to closing of state hospitals and focus on the adult homeless population, additional community trainings were not provided in 1992.

C. Planning

Base year:

- Homeless and runaway youth seen as the responsibility of the Department of Social Services and private agencies. No interagency planning involving DMH.
- Children of homeless families seen as responsibility of DSS and the Department of Public Welfare.

Most Recently Approved Plan (September, 1991):

- Assure that each Area, in its CCSS planning process, addresses strategies for provision of services in such a manner as to make them accessible to homeless families and children (September, 1992).

Revised or Additional 1992 Goals:

- Work with programs serving runaway and homeless adolescents and young adults to assure that the youths' mental health needs are met.

Current Implementation/Accomplishments:

- The need to tailor services to address the needs of the homeless was identified in CCSS planning documents. CCSS plans, due in Summer,1993, will be monitored for attention to the homeless
- Representatives from DMH, the Department of Social Services, the courts, the Department of Education and several programs serving homeless and runaway youth attended a regional planning in June organized through the CASSP technical assistance center at Georgetown. The Massachusetts attendees developed an agenda of priority issues. Regular meetings have been established to address such issues as Medicaid, managed care, and addressing the needs of homeless and runaway youth in area mental health planning.
- Representatives from programs serving homeless and runaway youth were added to the children's planning committee which provided input into the state plan and which is overseeing the planning for Comprehensive Community Support Systems.

Comparison with Base Year:
Significant progress was made in establishing an interagency process for addressing the needs of homeless and runaway youth, and for integrating these concerns into the agendas of DMH and the other public agencies. Availability of resources, however, dicta budget priorities in any given year

REQUIREMENT #IX: In the case of children with a serious emotional disturbance, the State plan-

(A) subject to sub-paragraph (B), shall provide for a system of integrated social services, educational services, juvenile services, and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act);

(B) shall provide that the grant under section 1911 for the fiscal year involved will not be expended to provide any service of such system other than comprehensive community mental health services; and

(C) shall provide for the establishment of a defined geographic area for the provision of the services of such system.

Developing links with DSS, the courts, local school systems and community agencies is integral to the planning for implementation of Comprehensive Community Support Systems. To accomplish this task, outreach efforts to include these organizations are taking place. DMH is also meeting intensively with Mental Health Management of America, Inc. (MHMA), the state's Medicaid vendor for mental health and substance abuse services, in order to assure that DMH and MHMA offer a seamless service system to children and their families. The Lynn CASSP Project, the plan for Metro Boston Interagency Services and the Casey Foundation Urban Mental Health Initiative are all exploring methods of collaborative service delivery. In addition, DMH continues to meet regularly with other agencies around special service coordination issues DMH has chosen **Interagency Entity, Interagency Agreements, Interagency Coordination** and **Informal Arrangements** as the indicators to demonstate implementation of this Requirement.

A. Interagency Entity

Base Year:

- The Executive Office of Human Services responsible for oversight of DMH, DPH, DSS, DMR, DPH, the Department of Youth Services, and the Office for Children
- The Office for Children advocates for children's needs, licenses children's programs, and leads Interdepartmental Teams to resolve disputes among agencies about responsibility for individual cases.

Most Recently Approved Plan (September, 1991):

- No goals identified related to interagency entity.

Current Implementation/Accomplishments:

- The Children's Social Policy Group continues to be the main interagency entity by which interagency policy and planning issues are addressed.

Comparison with Base Year:
Despite large cuts to the administrative infrastructure of EOHHS and its respective agencies, a structure remains in place for addressing interagency policy and planning issues, and for resolving disputes about particular cases.

B. Interagency Agreements:

Base Year:

- No interagency agreements existed with DSS in base year. In1989, an agreement was signed addressing responsibilities and procedures for crisis intervention and psychiatric hospitalization for children in the care or custody of the Department of Social Services

- Agreement signed August 1, 1987 between DMH and DMR regarding services to clients diagnosed as both mentally ill and mentally retarded.

- No agreements in place at state level between the Department of Education and DMH or other child-serving agencies in base year. In 1988, DOE-EOHHS agreement was signed by DOE, EOHHS, DMH, DMR, DPH, DSS, DYS, Mass. Commission for the Blind, Mass Commission for the Deaf and Hard of Hearing, Mass. Rehabilitation Commission, and Office for Children Agreement outlined protocols for early identification of children with multiple service needs to promote coordinated service delivery which can enable children to be served in least restrictive environment.

- Agreements in place with the Department of Youth Services addressing access to psychiatric hospitalization and aftercare for clients of particular DYS programs

Most Recently Approved Plan (September, 1991):

- Work with the Special Education Division of the Department of Education to identify prerequisites necessary to support a protocol to prevent out-of school district placements (February, 1993)

- Develop a workplan and process for moving a significant portion of DMH outpatient services into the schools to provide timely intervention and prevent out-of-home placement (Sept.,1992).

- Ensure that each Area is responsible for having agreements with the appropriate parties (DSS and the MHMA Regional Management Center) outlining procedures to be followed for DSS clients in need of crisis intervention, hospitalization, and aftercare.(FY'93 and ongoing).

Revised or Additional 1992 Goals:

- Advocate with MHMA to continue Medicaid coverage for school-based services.

- Develop agreement with MHMA defining DMH and MHMA responsibilities for crisis intervention, screening, hospital diversion services, and hospitalization. (March, 1992).

Current Implementation/Accomplishments:

- The EOHHS-DOE agreement to which DMH is a signatory remains in effect. The agreement is currently being updated, and the new agreement will be signed by January ,1993.

- DMH is exploring with the Department of Education the feasibility of developing a new agreement (similar to one in place between DOE and DMR), whereby DOE funds now spent on residential care for SED youth would be given to DMH to use for community mental health services which would enable the child to remain at home and in the community.

- The children's planning subcommittee met with the Director of Mental Health Management of America to express its concern about continued funding for school-based treatment. MHMA committed itself to continued funding of such services for at least one year.

- A MHMA-DMH agreement on respective responsibilities was negotiated.

- DMH coordinated joint meetings among MHMA, DSS, and DYS to ensure that issues regarding access to crisis intervention and hospitalization are fully covered, as these were items formerly covered in interagency agreements with DSS and DYS.

C. Interagency Coordination:

Base Year:

- State-level and area level trainings were conducted for DMH and DSS staff on interagency agreement on psychiatric hospitalization.

- Area level interdepartmental teams in place to resolve stuck cases.
- Joint Office for Children-DMH review of all proposals for mental health funding
- Interagency coordination varied according to area; planning boundaries for DSS and DMH almost identical.

Most Recently Approved Plan (September, 1991):

- DMH commissioner will meet with each head of child-serving agencies to develop mutual goals and objectives. (November ,1991)
- Disseminate report generated by the Lynn CASSP Demonstration project on interagency planning process, problems and achievements (October, 1992).
- Demonstrate collaborative relationships with schools and other child-serving agencies (March, 1992).
- Implement an interagency protocol in the MetroBoston Area to assure that out-of-home placements are prevented whenever possible (September, 1992)

Revised or Additional 1992 Goals:

- Revise goal of developing a workplan for placing outpatient services in schools Plan to enhance coordination with schools to be addressed as part of each Areas's CCSS plans (Summer, 1993)
- Develop interagency application to the Casey Foundation for mental health early intervention project in MetroBoston.
- Delay target date for dissemination of Lynn CASSP report until December, 1992, to accord with deadline for submission of CASSP final report.
- Ensure that each Area has agreements with the appropriate parties (DSS and the MHMA Regional Management Center) outlining procedures to be followed for DSS clients in need of crisis intervention, hospitalization and aftercare. (June, 1993).
- Work with EOHHS to examine current organizational boundaries for EOHHS child-serving agencies and assess mechanisms for enhancing coordination and simplifying service delivery (July, 1993).

Current Implementation/Accomplishments:

- DMH commissioner met with commissioners or designees in charge of children's services in key state agencies.

- Boston was awarded a planning grant from the Casey Foundation for FY'93 under its Urban Mental Health Initiative which will focus on coordinated early intervention in an urban minority neighborhood. State infrastructure issues will be addressed by the state level committee, being chaired by EOHHS, and involving DMH, DSS, DPH, DYS, DMR, DPW, Executive Office of Communities and Development. Issues such as coordination of Medicaid managed care with individual agency roles, single case management, and blended funding must be resolved in order for the state to receive an implementation grant.

- Lynn School Department actively involved in CASSP interagency serving planning project, Boston School Department actively involved in MetroBoston Interagency Planning Project and in Casey Foundation mental health grant.

- Report to the legislature on "Interagency Services for Children and Adolescents in MetroBoston" submitted April, 1992. The Legislature has indicated its intention to authonze $2.5 million in funding for the Metro Boston Interagency Project dunng FY'93.

Comparison with Base Year:
Although many items remain to be addressed, interagency coordination increasingly became a major theme for both state and local level planning. At the state level the respective roles of the state agencies' crisis intervention, psychiatric hospitalization, and aftercare were clarified and codified through interagency agreements Local coordination with the schools to prevent out-of-home placements initiated at the state level through an EOHHS-DOE agreement continues at the original pilot sites and was expanded The CASSP project, the MetroBoston Interagency Plan, and the Casey protocol produced useful models on which to build. As part of the CCSS planning process each Area will be developing its own interagency service agreements.

Supporting Narrative:

In response to fiscal constraints, both DSS and DMH cut administrative staff and reorganized their area boundaries, so that planning and service areas are no longer identical, and non-direct service staff available for interagency planning are limited. There is currently an advocacy effort underway to convince EOHHS of the need to recreate common "human service" boundaries. Items such as single case management, coordinated intake, and blended funding will be addressed through planning undertaken as part of the Casey grant, since the foundation has made clear it is looking for state-level systemic changes to address these issues, rather than waivers of existing procedures which would apply only to the target area for the grant.

D. Informal Arrangements:

- DMH currently participates on the following state-level interagency task forces and work groups:
  - The Family Support Steering Committee of the Massachusetts Developmental Disabilities Council.
  - The Committee to Restructure Child Welfare Services
  - The Casey Grant Steering Committee
  - Project Impact - a demonstration project to develop a continuum of care for adopted children.
  - The Committee on Child Mortality

PART C: STATE MENTAL HEALTH PLANNING COUNCIL

STATE MENTAL HEALTH PLANNING COUNCIL

The State Mental Health Planning Council was established, under P.L. 99-660, as a sub-committee of the Department's Statewide Advisory Council and includes consumers, family members, legal advocates, providers, other state agency personnel, mental health professionals and professional organizations, legislators, and a union representative. Membership includes family members of adults and children and members of cultural and linguistic minority groups. DMH provides staff to the Council.

Initially the Council appointed six sub-committees from among its own members and other interested individuals to address what were identified as the main issues in writing a comprehensive state mental health plan. These sub-committees were: **Adult Services**, **Child/Adolescent Services**, **Legal/Human Rights**, **Human Resources**, **Finance**, and **Minority Access**. Their work contributed to the Comprehensive Mental Health Service Plan (the most recently approved plan) written and distributed in May, 1991 and revised in September, 1991. The two sub-committees currently active are the Child/Adolescent and Minority Access groups. The latter was expanded substantially this year and is now the Multi-Cultural Advisory Committee with a greatly expanded agenda, and statewide membership of 125. A sub-group of this Committee serves as a sub-committee of the Planning Council.

The Planning Council and representatives of both sub-committees met on June 24, 1992 with the Commissioner and several DMH staff to be updated on DMH planning activities and to plan for the anticipated September 30, 1992 submission of the annual P.L.99-660 Progress Report. Although some members of the Committee have participated this year in statewide and Area level planning groups and were familiar with the development of Comprehensive Community Support Systems (CCSS), the Department's principal initiative, others were educated about the process and had an opportunity to ask questions. It was explained that the Department's intention is to integrate the CCSS planning process and the Area level planning committees with a statewide planning process. The goal is to write a new, multi-year State Plan by December, 1993.

Shortly after the June meeting the Department learned, officially, that new federal legislation (P.L.102-321) was signed that incorporates the requirements of what had formerly been P.L.99-660 into the state's block grant application process. The timing passage and new requirements contained in this legislation altered the Department's usual schedule of Planning Council meetings and the Council's review of the annual Progress Report. It also changed some of the Planning Council's responsibilities. In addition, with these changes, and the active planning going on at the Area level, the

Statewide Advisory Council decided to evaluate the membership of the Planning Council to ensure that all constituencies are actively represented and that membership conforms to P.L.102-321 requirements. At its November 20 meeting the Statewide Advisory Council approved a new membership roster for the Planning Council and set a meeting for early December to review a draft of the Department's block grant application, including the 1993 State Plan, and to make its recommendations to the Commissioner based on that review.

The Planning Council met on December 10, 1992 and reviewed both the 1993 State Plan (current additions and revisions to the approved Plan and 1993 Spending Plan) and the 1992 Annual Progress Report. The Council's comments and recommendations, in the form of a letter to Commissioner Eileen Elias, are included with the Block Grant Application.

Names of the State Mental Health Planning Council members follow as well as a summary of their affiliations.

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Department of Mental Health
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NUMBER OF PLANNING COMMITTEE MEMBERS BROKEN DOWN BY AFFILIATION

STATE EMPLOYEES & PROVIDERS		12
		10
	Subtotal:	22
FAMILY MEMBERS/ADULT		5
FAMILY MEMBERS/CHILD-ADOLESCENT		6
CONSUMERS		14
	Subtotal:	25
PROFESSIONAL ORGANIZATIONS		5
LEGISLATOR		1
LEGAL, HUMAN RIGHTS ADVOCATES		3
ADVOCATES		3
UNION		1
	Subtotal:	13
	TOTAL:	60

NOTE: Four members of the Council also sit on the Multi-Cultural Advisory Comittee

APPENDIX

FY93 BUDGET OVERVIEW

11/25/92

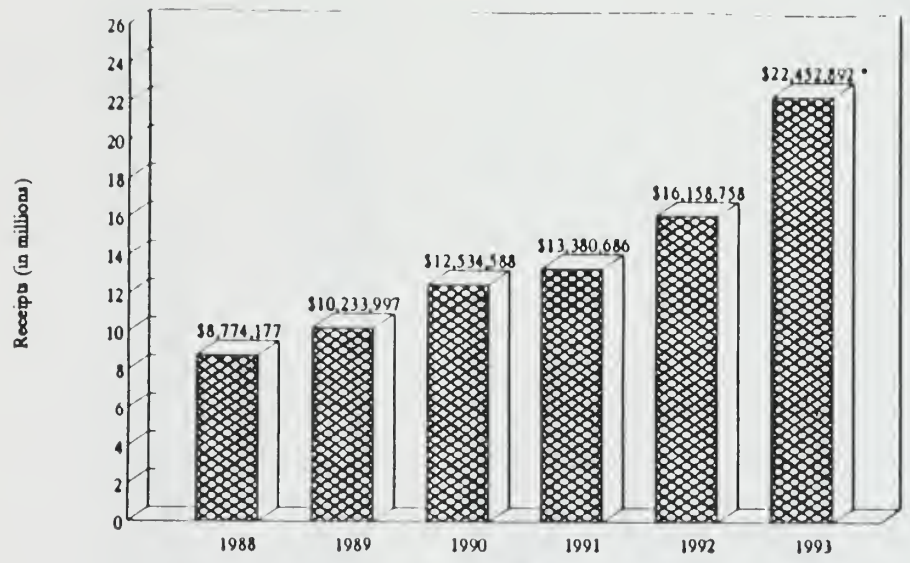
FISCAL YEAR COMPARISON BY ACCOUNT		FY 92 AVAILABLE	FY 93 TOTAL	INCREASE/ DECREASE
ADMIN	5011-0100	16,031,598	15,136,736	(894,862)
ADULT	5046-0000	156,329,097	200,883,136	44,554,039
	5046-1501	6,000,000	0	(6,000,000)
	5046-3000	0	2,000,000	2,000,000
RENTAL SUBSIDIES		2,093,893	2,516,940	423,047
KIDS	5047-0000	45,485,201	45,285,201	(200,000)
FORENSIC	5049-0000	5,354,782	5,317,704	(37,078)
CMHC'S	5051-0100	81,383,481	77,854,404	(3,529,077)
FACILITIES	5095-0000	141,284,487	118,295,314	(22,989,173)
(GAEBLER)	5047-4000	7,019,830	6,488,839	(530,991)
	S- TOTAL	148,304,317	124,784,153	(23,520,164)
MR RESERVE		2,400,000	0	(2,400,000)
TOTAL:		$463,382,369	$473,778,274	$10,395,905

ADULT - 5046 SUMMARY	
FFP	9,816,500
NEW RESIDENTIAL ANNUALIZATION	15,818,711
ACUTE CARE PRIVATIZATION	13,918,828
INTERMEDIATE CARE	3,000,000
CONTINUING CARE	2,000,000
TOTAL:	$44,554,039

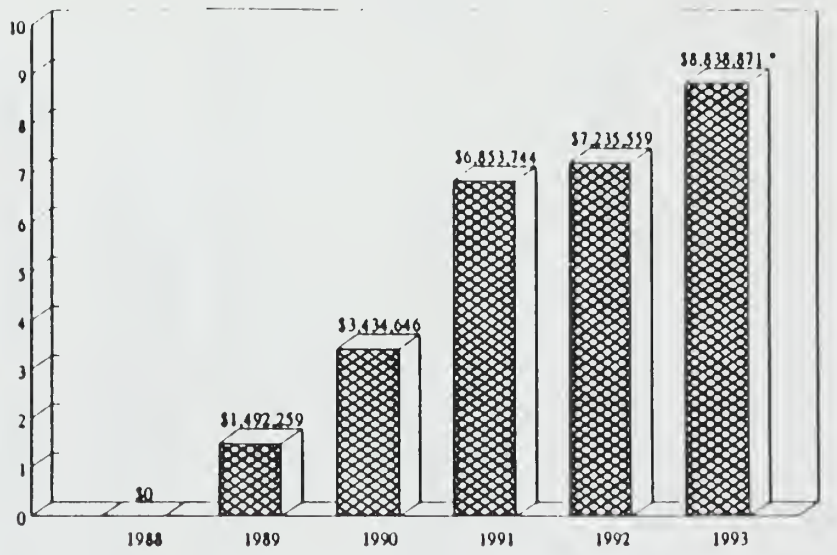
- STATE HOSPITAL- SUMMARY	FY 92 COST	FY 93 PROJECTED COST	FY 92 TO FY 93 CHANGE
NORTHAMPTON	11,604,170	4,470,276	(7,133,894)
WORCESTER	28,525,804	27,643,115	(882,689)
TEWKSBURY (DANVERS)	19,255,603	13,782,978	(5,472,625)
MET. STATE	12,350,355	143,372	(12,206,983)
TAUNTON	21,916,269	22,125,406	209,137
WESTBOROUGH	25,438,373	25,383,432	(54,941)
MEDFIELD	17,491,239	18,038,296	547,057
BRIDGEWATER	3,399,543	3,401,692	2,149
GAEBLER	7,019,830	6,488,839	(530,991)
	0	0	0
TOTAL:	$147,001,186	$121,477,406	($25,523,780)

DEPARTMENT OF MENTAL HEALTH

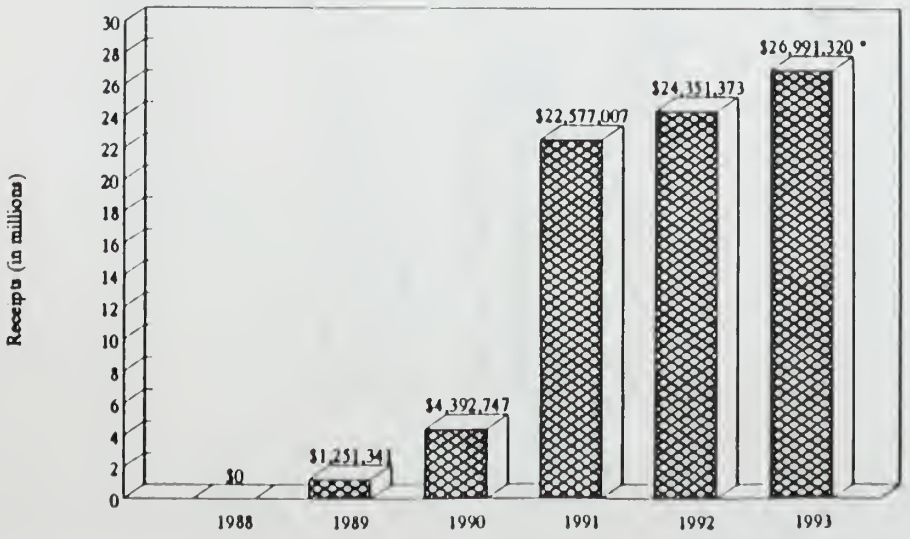
Facilities Revenue Growth
By Fiscal Year



Adolescents Revenue Growth
By Fiscal Year

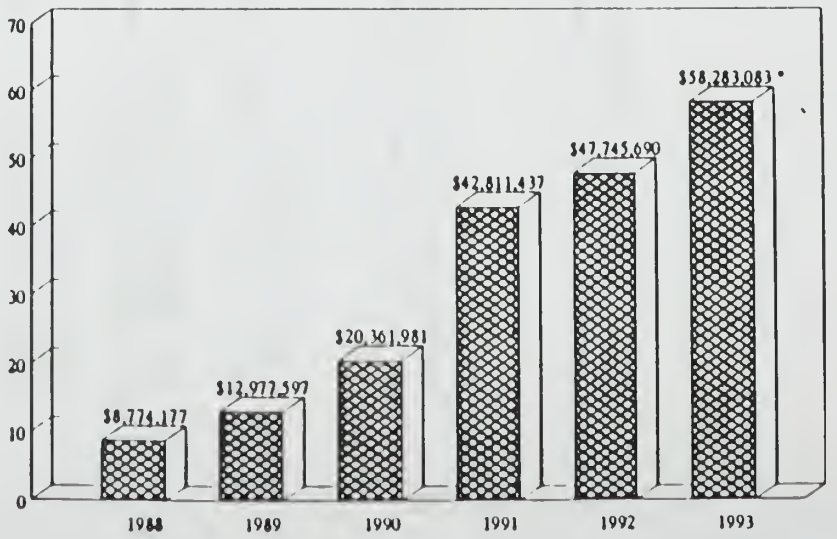


Community Revenue Growth
By Fiscal Year



* = Projected Revenue

Total Revenue Growth
By Fiscal Year



* = Projected Revenue

PROGRAMS SERVING MULTI-CULTURAL AND LINGUISTIC MINORITY GROUPS

Metro Indo-Chinese Child & Adolescent Services - Chelsea
South Cove Health Center - MICAS (Metro Indo-Chinese Services)
70 Clients

Haitian Mental Health Unit - Cambridge
Haitian Mental Health Unit, Cambridge Hospital
220 Adults (*approx.) ***80 kids (*approx)***

Indo-Chinese Psyhciatry Clinic - Boston
South Cove Health Center - Indo-Chinese Outpatient Services
114 Adults ***153 Kids***

Inqulinos Boricuas En Accion - Boston
Inquilinos Boricuas En Accion (Hispanic Family Support)
57 Clients

Concllio Hispano De Cambridge
Concilio Hispanic De Cambridge
100 Clients

North Suffolk Mental Health Assoc. (Hearing Impaired Outpatient)
103 Clients

North Suffolk Mental Health Assoc. (Community Support)
261-Hispanic Clients ***79 Asian Clients***

Mass. Mental Health Research Corp- (Hispanic Outpatient Services)
3,074 Clients

St. Ann's Home -Methuen
Residential Treatment Center for emotionally disturbed children
18 Clients

Alianza Hispana - Boston
217 Clients/Outpatient ***76 Clients/Clubhouse***

Dorchester Counseling Center, Inc., - Dorchester
15 Haitians 15 Hispanic 5 Portuguese 2 African
297 clients with other linguistic needs

Gandara Mental Health Center - Springfield

Community Support	*950 Clients*
Psych. Day Treatment	*30 Clients*
Outpatient	*74 clients*
	(Capacity 60)
Family Support	*17 Families Served*
Residential	*8 Beds*
	(7 Clients - 1 vacancy)

Hyland House, Inc. - Fall River & New Bedford

	HYLAND HOUSE	HERITAGE HOUSE
White	97%	88.6%
Black	1.3%	7.2%
Hispanic	.4%	3.6%
Oriental	.4%	--------
Portuguese	---------	--------
Asian	---------	--------
Other	.9%	.6%
	216 hrs	193 hrs

	POLARIS	RESPITE
White	89.4%	99.98%
Black	2.35%	.026%
Hispanic	--------	---------
Oriental	--------	---------
Portuguese	7. %	---------
Asian	1.25%	---------
Other	--------	.008%
	85 hrs	116 hrs

Hyland House CON'T

NEW BEDFORD

White	41.%
Black	5.%
Hispanic	1.%
Oriental	
Portuguese	40.%
Asian	3.%
French	10.%
Other	---

5122 contacts

Roxbury Youth Works, Inc. - Boston
This is a psychological testing contract;
the capacity is 2688 HOURS

South End Community Health Center -Boston
Spanish speaking only
526 Adults ***226 Kids***

Spanish-American Center, Inc. - Leominster
3-5 Families at one time - 1000 Hours provided

DMH POLICY #87-3

CASE MANAGEMENT SERVICES

The Commonwealth of Massachusetts
Executive Office of Human Services
Department of Mental Health
160 North Washington Street
Boston, Massachusetts 02114

EDWARD M. MURPHY
Commissioner

AREA CODE 617
727-5660

MEMORANDUM

TO: Distribution

FROM: Edward M. Murphy

Policy No.: 87-3

RE: Policy Establishing Case Management Services

DATE: April 15, 1987

Effective Date: April 15, 1987

Responsible Manager/Contact Person:

Henry Tomes, Ph.D.. Deputy Commissioner for Mental Health Services

Functional Unit: 4000

Telephone Number of Contact Person: 727-5660

Content of Policy:

A policy on Case Management Services is established to provide for a comprehensive Case Management System to include case management programs for mentally ill adults, children and adolescents. It is the intention of the Department to establish a unified Case Management System. At present, this policy applies to all DMH areas in the state, with the exception of those in District I. Case management services in District I will continue to be bound by orders issued in the Brewster case and by 104 CMR: 15.00, 16.00 and 17.00.

This policy is issued to begin the implementation of the requirements of Section 24 of Chapter 19, and the Governor's Special Message on Mental Health.

Administrative procedures for the Implementation of the Case Management Policy are currently being prepared. Prior to issuance, these procedures will be circulated for review and comment.

If there is any question regarding the Policy on Case Management, please contact Jan Nisenbaum, Deputy Commissioner's Office, at 727-5660.

EMM/ere

The Commonwealth of Massachusetts
Executive Office of Human Services
Department of Mental Health
160 North Washington Street
Boston, Massachusetts 02114

EDWARD M. MURPHY
Commissioner

AREA CODE 617

POLICY ON CASE MANAGEMENT SERVICES

APRIL 15, 1987

SECTION A: PURPOSE

It is the policy of the Department of Mental Health to implement a consistent statewide Case Management System for severely disabled mentally ill adults and seriously mentally ill or emotionally disturbed adolescents and children. The Case Management System is the mechanism through which the Department of Mental Health (DMH) carries out its dual responsibility to identify and be accountable for all seriously and long-term mentally ill persons in Massachusetts, and to allocate its service resources in the most effective manner to meet the needs of these individuals. The purpose of the Case Management System is:

1. To identify and engage in services those individuals who, because of seriously disabling mental illness, are in need of intensive and long-term services and therefore are the primary responsibility of the Department of Mental Health;

2. To maintain continuous contact with those identified individuals to ensure continuity of service provision and to maintain accountability of the DMH system for these clients;

3. To allocate available DMH-funded service resources to these priority clients based upon individual client needs;

4. To facilitate access of these priority clients to all available benefits, entitlements, and opportunities, such as SSI, Medicaid, subsidized housing, and employment and training programs;

5. To monitor the responsiveness, quality, and effectiveness of services provided to priority clients;

6. To provide client-based information on individual needs and identify gaps in services as a basis for program development and budget planning.

SECTION B: ELIGIBILITY

I. ADULTS

1. Case management services are to be provided to individuals suffering from a serious, long-term mental illness that includes a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet ordinary demands of life. (Primary disorders of alcoholism and substance abuse are excluded.); and/or

2. As a result of serious, long-term mental illness have an inability to meet independently life support needs of food, shelter, clothing, management of finances, and health care.

Examples of clients meeting the above criteria include those with a history of repeated psychiatric hospitalizations and a history of poor or inconsistent compliance with mental health treatment programs.

II. CHILDREN and ADOLESCENTS

Case management services are targeted to those children and adolescents, through 21 years of age, who are suffering from serious mental illness. In particular, the Case Management System will address the needs of those children and adolescents identified in the Governor's Executive Order 244, that is, mentally ill and seriously emotionally disturbed persons under the age of nineteen (19), and those mentally ill persons aged nineteen (19) through twenty-one (21) who are receiving structured Chapter 766 services. Specifically, this includes Executive Order 244 populations receiving inpatient hospitalization, residential or day/vocational services; or referred for hospitalization, residential, day/vocational services; clients referred to DMH from the EOHS Interdepartment Team; any person participating in the Psych Under 21 Medicaid Program; persons 19-21 years of age who are not Executive Order 244 eligible, but meet the adult criteria for eligibility for case management services.

III. PRIORITY CLIENTS FOR CASE MANAGEMENT SERVICES

Priority for case management services shall be given to eligible clients in the following order:

1. Persons who are awaiting discharge from DMH inpatient units; and homeless long-term, mentally ill persons;

2. Persons who have had two or more hospitalizations in a mental health facility within the past twelve (12) months;

3. Persons who by reason of mental illness are rendered unable to meet life support needs of shelter, food, clothing, and self-care;

4. Persons who are currently residing in a DMH or contracted intensive residential treatment program;

5. All other clients determined eligible for case management services under this policy.

SECTION C: FUNCTIONS OF CASE MANAGERS IN THE CASE MANAGEMENT SYSTEM

Case managers in the DMH Case Management System will perform the following client based services:

1. Aggressive Outreach - To identify and engage in service those clients meeting the eligibility criteria;

2. Intake and Assessment - To determine eligibility and priority for DMH services and, in conjunction with the client's primary care clinician, arrange for comprehensive assessments as a basis for service planning;

3. Service Planning and Service Authorization - To coordinate the development of the client's Individual Service Plan (ISP) and to ensure implementation of the ISP. Authorization of DMH funding and admittance to DMH operated programs to provide specified ISP services, must be approved by the DMH Area Director or his/her designee;

4. Service Monitoring and Case Review - To monitor the delivery of specified services, and to amend service plans and authorizations as client needs change;

5. Advocacy - To work on behalf of clients to ensure equity, due process, and access to applicable rights and privileges.

Case managers are not the client's primary clinician, and are not providing professional clinical services to the client. However, case managers must have clinical skills and training, and must be supported by professional clinicians. All case managers will receive standardized training by DMH.

SECTION D: ADMINISTRATIVE PRINCIPLES

All Case Management Systems supported by DMH must adhere to the following principles:

1. The Case Management System will operate under the direct administrative control of the Area Director for each service area. Case management services will be state operated and state staffed unless a specific performance contract is approved by the Deputy Commissioner for Mental Health Services. Such performance contracts may be executed where there is only one primary provider of mental health services in an Area, where the case management service is administratively independent from other service components within the provider's operations, and where, at a minimum, all other requirements of this policy will be fully met by the provider;

2. The Case Management System combines and standardizes basic case management functions for eligible adults, adolescents, and children. Case managers may specialize in serving certain age groups or other types of clients, but they will operate under one general administrative entity;

3. All Case Management Systems, including provider operated systems, must utilize the DMH Client Information System and must comply with all specified reporting and documentation requirements. All case management providers must provide authorized DMH personnel access to case management records in accordance with 104 CMR: 15.03 (9);

4. Each Area must maintain a 7 day, 24 hour on-call system for accessibility to the Case Management System. This will ordinarily be accomplished through an affiliation agreement with the Area's emergency service system;

5. At the time of client application, the client, family and/or guardian as appropriate, shall be informed of all client's rights.

6. If a client or other interested party believes that the determination of ineligibility for case management services constituted an illegal, inhumane or dangerous action, the decision may be appealed. The appeal process is governed by 104 CMR: 24.00;

7. Individuals referred to, or applying for, case management services must receive an intake review to determine eligibility for case management services within five (5) working days of the initial application. In the instance of individuals who are homeless, the initial interview shall be completed within 24 hours of the application;

8. Active cases shall be reviewed at least every six (6) months by the Case Management System, and service plans may be amended to address changes noted in each client's condition upon review. In conjunction with the client's clinician(s), a complete reassessment will be conducted for each client on an annual basis;

9. Client confidentiality shall be protected in accordance with 104 CMR: 15.03 (9).

DMH Policy 89-3 on DMH Priority Clients

The Commonwealth of Massachusetts
Executive Office of Human Services
Department of Mental Health
160 North Washington Street
Boston, Massachusetts 02114

EDWARD M. MURPHY
Commissioner

COMMISSIONER'S POLICY MEMORANDUM

SUBJECT:

Eligibility Criteria for DMH Priority Clients

POLICY #: 89-3

DATE OF ISSUE: April 4, 1989

EFFECTIVE DATE: July 1, 1989

APPROVAL BY COMMISSIONER:

Signature Edward M. Murphy **Date** 4.4.89

I. Purpose and Scope of Policy

The purpose of this policy is to establish eligibility criteria for DMH priority clients. Chapter 599 established a new primary mission for the Department of Mental Health to "provide services to citizens with long-term or serious mental illness". This mandate clearly requires the Department to refocus and, where necessary, reorganize its programs and services to serve persons who are priority clients under the Chapter 599 mandate. DMH resources will be targeted to eligible service recipients regardless of their ability to pay. Third party reimbursement or client funds will be accessed when service recipients have this alternative available. Based upon available resources, services will be available to priority clients most in need of those services.

The primary mission of DMH is to direct its services to seriously or long-term mentally ill adults and seriously emotionally disturbed children and adolescents. The Department must target its resources to provide a comprehensive range of programs and services to meet the needs of these priority clients. As priority clients, seriously or long-term mentally ill adults and seriously

emotionally disturbed children and adolescents may access the full range of more intensive or longer term DMH services.

Eligibility for priority clients is based on three components: the presence of a serious or long-term mental illness in an adult or serious emotional disturbance in a child or adolescent; the severity of the illness as indicated by level of functioning; and, duration. Appropriate transition plans will be developed for clients presently in long term services to ensure implementation of this policy consistent with client needs and with applicable legal obligations.

II. General Eligibility Criteria

All persons determined eligible for long-term DMH services must meet the following criteria. As a DMH priority client, adults must have a long-term or serious mental illness and children and adolescents must be seriously emotionally disturbed.

Serious or long-term mental illness means a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgement, behavior, capacity to recognize reality or ability to meet the ordinary demands of life. Serious mental illness does not include symptoms like the above caused solely by alcoholism, drug intoxification, mental retardation or organic brain damage.

A seriously emotionally disturbed child or adolescent is one whose progressive personality development is interfered with or arrested by a variety of factors so that there is impairment in the capacity expected for the child/adolescent's age and endowment. Thus, these children and adolescents will have a diminished capacity to reasonably and accurately perceive the world around them, control their impulses, maintain satisfying or satisfactory relations with others, or to learn.

Serious or long-term mental illness includes Schizophrenia and disorders of affect and personality, and other disorders depending on the severity and duration of the illness. Seriously emotionally disturbed children and adolescents may have disorders of impulse control or attention deficit. However, all persons meeting the general eligibility criteria must also meet the severity/functional and duration criteria outlined in the following sections.

III. Severity/Functional Criteria

1. Adults

In addition to having a serious or long-term mental illness, adults must meet one or more of the following criteria. A DMH priority client is a seriously or long-term mentally ill person, 19 years of age or older, who:

a. requires psychiatric hospitalization

The operational guideline is that the client meets all civil commitment criteria or is unable to function without the structure and programmatic interventions provided by a public or private psychiatric facility. Behavior is considerably influenced in communication or judgement, or there is an inability to function in almost all areas.

b. is currently at high risk of psychiatric hospitalization

The operational guideline for "high risk" is that the client meets or has met civil commitment criteria within the last year or would meet commitment criteria in the absence of psychiatric intervention. "High risk" may include documented evidence during the last year of persistent danger of hurting self or others, including a preoccupation with suicidal thoughts, attempt at suicide or serious bodily harm to self with or without the expectation of death, frequently violent, manic excitement, or clear verbalization of intended physical harm to another.

c. is unable to secure adequate shelter, food or clothing

The operational guideline is an inability to independently secure and maintain shelter which meets building code, inability to independently secure food which meets minimum dietary needs, and inability to independently secure clothing in sufficient quantity and variety for personal hygiene and environmental conditions.

d. required placement in a structured residential program

The operational guideline is an inability to live independently. Intermittent or continuous staff support in the residential setting is needed to assist the client with activities of daily living, including self-care, money management, etc.

e. is unable to work competitively

The operational guideline is an inability to independently secure competitive work and to sustain competitive work for at least six months duration. In addition, income derived from competitive work must be sufficient when combined with other sources of income to meet minimum shelter, food, and clothing needs as described above.

f. is unable to establish or maintain social support relationships

The operational guideline is an inability to independently develop/maintain relationships for the purpose of social, recreational, or leisure activities, or for the purpose of exchanging social support in the form of assistance relating to life tasks (e.g., transportation) or provision of tangible resources (e.g., food, clothing, shelter) or emotional support (e.g., empathy, advice, recognition).

2. Children and adolescents

A child/adolescent, along with his/her family, is eligible for long-term services if his/her impaired functioning or behavior is assessed to be caused by serious mental illness or serious emotional disturbance, and if he/she can be categorized by one or more of the descriptions below.

a. is dangerous to self or others

The operational guideline is the definition of danger to self or others in G.L.C. 123, s.1.

b. is currently at high risk of hospitalization

The operational guideline is the definition of danger to self or others in G.L.C. 123, s. 1.

c. is aggressive/assaultive/acting out against person or property

d. is a perpetrator of reportable physical, sexual or psychological abuse or neglect

e. is experiencing severe apathy/withdrawal

f. is unable to adjust to less-restrictive special education program

The operational guideline is that the inability

to adjust to Chapter 766 program creates a risk of requiring a more restrictive placement.

g. is unable to cope with daily living pressures
The operational guideline is an inability to cope reflected by, at minimum, an inability to function except when protected and supported by others, difficulty in performing appropriate vocational/educational activities, very restricted personal interactions, and difficulty in performing daily living activities and role functions.

h. is a victim or key member of a household where reportable abuse/neglect or severe assault has occurred within the past two years

i. is homeless or has substantial agency involvement and has a functional disability which presents substantial limitations in two or more major life activities
The operational guideline for functional disability in life activities includes limitations in self-care at an appropriate developmental level; perceptive and expressive language; learning; self-direction, including behavioral controls, decision making, judgement and value systems; and capacity for living in a family or family equivalent. The operational guideline for substantial agency involvement or homelessness includes the child or adolescent who is in the care or custody of the Department of Social Services; the child or adolescent who is committed to the Department of Youth Services; and, the child or adolescent who has no residence.

j. needs frequent adjustment or close monitoring of psychotropic medications or combination of psychotropic and other medications.

IV. Duration Criteria For Adults, Children and Adolescents

The duration of a mental illness or emotional disturbance may be associated with the type of disorder. In addition, individuals with a given illness or disturbance may experience an increase or decrease in the severity of symptomatology. For these reasons, duration as an eligibility criteria is defined in terms of severity of symptomatology over time. Generally, where the

severity/functional criteria do not specify the time period during which the criterion must be exhibited, the duration criterion is a period of one year. The duration criterion should be interpreted as met if:

1. the client meets the criteria related to serious or long-term mental illness or in the case of a child or adolescent, serious emotional disturbance, and has exhibited one or more of the severity/ functional criteria within the preceding year; or,

2. the client meets the criteria related to serious or long-term mental illness or in the case of a child or adolescent, serious emotional disturbance, and is expected to exhibit one or more of the severity/functional criteria during the succeeding year.

V. Emergency/crisis intervention services will be provided to any individual experiencing a mental health crisis. Access to these services, up to 72 hours, will not be limited. DMH maintains a commitment to ensuring that these services will be available to any individual in need of emergency mental health care.

VI. Evaluation/assessment and short-term services will be available to any adult or child/adolescent in need of these services. An evaluation/assessment will be conducted by a qualified clinician to determine the individual's need for mental health services and will not exceed four (4) sessions with the identified client. If necessary to prevent further decompensation, short-term treatment will be available to persons experiencing an acute mental health disorder who are in need of medication or outpatient support. The evaluation/assessment and short-term services may not exceed a total of seventeen (17) sessions in a year.

VII. Adult Case management, residential, day services, aftercare or community support services are available only to priority DMH clients. Individual services may establish further eligibility criteria to assist in prioritization of clients in need of those services.

VIII. Child/adolescent case management, residential, day and support services are available only to priority child/adolescent clients. Additional eligibility criteria are established for these services in order to assist in prioritization of priority clients most in need of those services.

** The paraphrased definition of seriously emotionally disturbed child or adolescent comes from Crisis in Child Mental Health, a report of the Joint Commission on Mental Health for Children.